

Health behavior among female migrant sex workers in Oslo, Norway

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Abstract

In a public health perspective there has been a strong focus on HIV/AIDS and STDs when addressing the health of sex workers. However, a more holistic approach to the topic of sex work and health has been called for, both in terms of research, interventions and services. This project is a contribution to the somewhat neglected research issue of sex work and health in a Norwegian context. This study explores the health behaviour among female migrant sex workers in Oslo, Norway.

Through a qualitative study based on observations and interviews with female migrant sex workers and service providers, it has been examined how this group of sex workers define their health, meet their health needs and how this is interpreted in a Norwegian health care setting. The study emphasises the interlinkage between health beliefs, health behaviour and service utilization. It shows the importance of focusing on how the social and cultural context form and influence this group's understanding of their own health and illness, and what is seen to be appropriate action in terms of prevention efforts or treatment seeking. Throughout this study it will be argued that focusing on individual health beliefs are not enough to explain this group's health behaviour, as social relations, interactions and structures also affect how these women make decisions about their health and how they utilize health services.

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1. Introduction

Being a sex worker can have many consequences for a person's health, of both psychological and physiological nature (Sanders 2004). A lot of the research done on health and sex work from a public health perspective has focused on sexually transmitted diseases (STDs) and HIV/AIDS. This has also been the rationale for a lot of intervention programs aiming at increasing safe-sex behaviour among sex workers and their clients (Vanwesenbeeck 2001). This focus was especially evident through the commitment of major actors and agencies within the United Nations (UN), like UNAIDS and the World Health Organisation (WHO). Recently, it has been argued that the wider health needs of sex workers must be recognized, and that health services targeting this group should not only be limited to a focus on STDs and HIV/AIDS (Alexander 1998). A more holistic approach to sex work and health has been called for, both in terms of research, interventions and services (Mak 2004, Sanders 2004). This thesis is a contribution to this debate by its holistic approach when studying health behaviour among female migrant sex workers in Oslo, Norway.

In an international perspective sex work in Norway occurs on a small scale. Oslo, the capital of Norway, is the city that has the largest number of sex workers with an estimation of 1230 street-based sex workers and 1440 working from other arenas like apartments or massage parlours (Pro Sentret 2009, Tveit & Skilbrei 2008a). Nevertheless, during the last couple of years sex work has become an increasingly debated issue in Norway, something which has been reflected by the agendas of various political parties and an immense media attention. Much of this attention has been ascribed to the influx of foreign women in the sex market (Jahnsen 2008). The debate reached a climax the fourth of November 2008 when the Justice Committee passed a law proposal to the Parliament, making it illegal to buy sex in Norway from the first of January 2009. As a preparation to the upcoming law the Department of Justice wanted a mapping of the Norwegian sex market, and this was conducted by the research institute Fafo (Tveit & Skilbrei 2008a). However, this report did not include a particular section on health. This is not surprising, given the fact that sex work and health has been a relatively neglected research area in a Norwegian context. Even though public health perspectives act as foundations for different services targeting sex workers, no major attempts have been done to better understand this group's health behaviour. As mentioned, migrant sex workers have been an increasing part of the sex market and this group has been

seen to be even more vulnerable regarding issues related to health, in terms of access to health services and unstable, difficult life situations. It is therefore important to explore this particular group's health behaviour and how this is addressed in a Norwegian setting¹.

1.1 Rationale for the study

As previously stated, there have been few research attempts to examine the topic of migrant sex workers and health in Norway. Especially little is known on how this group of sex workers view their own health and what experiences they have had with health care services in Norway. This study aims to address this somewhat forgotten field by focusing on how this group defines and deals with different types of health needs. The overall objective of this study is:

To explore the health behaviour among female migrant sex workers in Oslo, Norway.

To answer this I will focus on and explore three specific research questions:

- How do female migrant sex workers' health beliefs influence their health behaviour?
- How are these beliefs and set of interrelated behaviours interpreted and understood in a Norwegian health care setting?
- How does the health behaviour of female migrant sex workers affect their service utilization in Norway?

Health behaviour was chosen as an appropriate approach for examining the issue of health and female migrant sex workers, because such a framework opens up for an exploration of how these women interpret their own health, well-being, risk and illness. In addition, it can give insight into how decisions are taken in search of prevention or treatment, and how actions are motivated or discouraged.

¹ http://www.prosenteret.no/index.php?option=com_content&view=article&id=48&Itemid=62

In this project service providers were regarded as a valuable source of information for obtaining knowledge about the research questions posed. Service providers interact with numerous migrant sex workers over time and across a wide range of health services. Thus, they are seen to have a rich understanding of these women's health needs, challenges and how to best address these. Additionally, service providers present an angle into how the cultural and social world of these women is understood in a Norwegian health care setting.

This thesis will give valuable insight into a field where much more research is needed. It is an important contribution to understand the health behaviour of this group of sex workers and how this is contextualised in a Norwegian setting. Gaining a richer knowledge on this research topic is crucial for evaluating existing services and for further policy recommendation.

1.2 Structure of the thesis

In chapter two central concepts and definitions are presented, and the issue of sex work and health is examined in the light of existing literature. Thereafter, a brief description of sex work in a Norwegian context and the most important services targeting sex workers in Oslo is given. This is intended to provide a contextualisation of the topic and create a background for the following parts. Finally, the definition of a health behaviour framework, as it is used in this study, is discussed. In chapter three the methodology of the research project is outlined and discussed, giving considerations to various issues regarding the fieldwork. Chapter four is a discussion of health beliefs and health behaviour, drawing on the findings from this study as well as relevant research contributions. In chapter five the issue of health behaviour and service utilization is examined and discussed. Ultimately, chapter six will provide a conclusion with the main discussion and findings of the study, followed by future recommendations.

2. Conceptual background

This chapter provides the background and contextual setting for the rest of the thesis. After definitions and concepts central to the thesis are outlined, the issue of sex work and health will be examined in terms of existing literature on the topic. Then, sex work in a Norwegian context will be presented, followed by a short description of the major services targeted at this group in Oslo. Finally, a framework for health behaviour as it is used in this thesis will be presented, as well as an argumentation for why this is a suitable approach for this project.

2.1 Definitions and concepts

2.1.1 *Sex work*

Writing about women that sell sex always poses a question of what terminology to use. The official standpoint of the WHO is that sex work should be used instead of the term prostitution as it is considered to be less stigmatizing². The rationale of this argument is that sex work emphasises the income generating aspect of the activity, whereas the term prostitution is seen as more associated with the moral discussion of those that sell sex and the moral implications of this activity (UNAIDS 2007, 2002). By focusing on how this activity is a source of livelihood, it is thought that sex work is a more neutral term. However, it is heavily contested whether the term is in fact neutral and what consequences such a definition has in a wider framework. The term sex work is linked to a wider theoretical and political debate about how one views the act of selling or trading sex for goods or money. Sex work is therefore not an unchallenged term and there is no universal consensus on whether one should use this definition over others (Bernstein 1999, Overall 1992). It is thus acknowledged that there is an ongoing discourse where the different terms, such as sex work and prostitution, are tied to several view points. However this discussion will not be further addressed, as it has no implications for the scope or focus of this thesis. Since this project focus on health, the term sex work has been chosen, as this is the term preferred by the

² http://www.euro.who.int/aids/prevention/20031120_6

WHO. The terms sex work and sex workers should in this thesis not be read as a political standpoint in the ongoing debate. It should merely be understood as a person who regularly receives money from a customer in exchange for sexual services, excluding other parts of the sex industry like stripping and pornography.

2.1.2 Female migrant sex worker

In this thesis the term migrant is defined as people that cross international borders and does not include internal migration within a country. The term female sex worker is in this context first and foremost used as a denominator for women that travel to Norway, sell sex in the country for different reasons and stays in the country on a temporary basis. This means that a migrant in this context is someone being in Norway legally, on some sort of visa, or illegally. A common trait is that they do not have any type of residence permit and have few or no formal health care rights. Migrant sex workers that have been in the country for a longer time period of time and has acquired some kind of residence permit are not included in this project. This does not imply that this group of sex workers do not face challenges within the health care system; it is however a demarcation based on the fact that they have more health care rights. Having few or no rights is likewise associated with having even more complex challenges related to health and health seeking behaviour (Ottesen 2008, Gülcür & İkkaracan 2002).

During the last years there has been an increase of foreign female sex workers in the Norwegian sex market and this group now makes up a significant part of this market (Tveit & Skilbrei 2008a). The female migrant sex workers can broadly be divided into women from Eastern European countries and women from Nigeria. Among the Eastern European group some have legal status in a member country of the European Union (EU) or the European Economic Area (EEA), and some come from countries which are not part of this agreement. The Nigerian sex workers are not originally from an EU/EEA country, but very often have some sort of residency in such a country, typically Italy or Spain. These are usually referred to as third country citizens. In addition there are also some which have no legal papers or visa, and who stays in the country illegally. Those women that come from a member country

of the EU/EEA have legal rights to work in Norway³, yet they often lack working experience, formal education or language barriers which make it difficult for them to enter the labour market. Without any formal work in Norway, it is difficult to qualify for a formal staying permit which results in few social rights, including health care rights (Norli 2008, Ottesen 2008). Tourists from member countries in EU/EEA have the right to emergency and necessary treatment as they are covered under the National Insurance Act. Tourist from such countries still have to pay a small fee as this is required by all Norwegian citizens before obtaining free health care⁴. Those that are in Norway as tourists from a country outside the EU/EEA have few health care rights, and they have to purchase private insurances to pay for medical expenses while they are in Norway. Those that are in the country illegally have even fewer rights, but both they and tourists outside EU/EEA without insurance are, however, entitled to emergency and acute care⁵.

When addressing the issue of female migration, the question of whether it has been voluntary or forced is likely to come up. Much literature has been written on the feminization of migration and it is often tied to the discussion of human trafficking (Gülcür & İkkaracan 2002). In this study no categorization has been made between different sex workers according to the definition of human trafficking. Such a distinction would have been significant if some of the participants had been here on a reflection period⁶. This is because a reflection period gives entitlement to a package of services, including certain social and health rights. Hence, those that might be defined as victims of human trafficking by the legal definition of the term, but are not part of the reflection period scheme, have no more or less rights than other migrant sex workers. On the basis of this and the fact that none of the

³ <http://www.udi.no/templates/Tema.aspx?id=9337>, note that specific rules apply to those countries that have newly acquired a membership in the European Union. These are: Poland, the Czech Republic, Hungary, Latvia, Lithuania, Estonia, Slovenia, Bulgaria and Romania.

⁴ <http://www.nav.no/English/Staying+in+Norway/Tourists+in+Norway>

⁵ <http://www.lovdato.no/all/hl-19990702-063.html#2-1> Lov om pasientrettigheter § 2-1.

⁶ Those that identify themselves as victims of human trafficking and seek help will be offered a reflection period. This means a legal stay in Norway for 6 month. During this time the person can assess their situation and decide whether they wish to co-operate with the police in investigating and persecuting the organizers. The person will be given a range of social and health services, including a safe place to live, counseling and a working permit. See also: http://www.rosa-help.no/pdf/rosa_english.pdf

participants in this study were in Norway on a reflection period, there was not made a distinction between female migrant sex workers and victims of human trafficking.

2.2 Sex work and health

Access to health care for female sex workers is a complex issue that relates to the women themselves and their surroundings. Stigmatization is an aspect that can act as a barrier for obtaining health care among sex workers (Chacham et al. 2007, Stadler & Delany 2006, Aral et al. 2003). The concept of stigmatization will in this context mean restricted access to a lot of public spheres as being identified as a sex worker often means that you are socially excluded and viewed as “untouchable”. This way of viewing sex work is based on moral values and people selling sex are very often seen as immoral and deviating from socially accepted behaviour. Ascribed categorization and labelling are important determinants for one’s own behaviour, as they influence expectations and self image. Stigmatization by others can lead to an increased feeling of shame and low self-esteem which can make it difficult to seek health care, since you expect that others will treat you poorly or you do not feel worthy or important enough for treatment. On the other hand it is sometimes the case that health service providers have negative attitudes towards sex workers and that this affects the quality of care given (Chacham et al. 2007, Aral et al. 2003). A study done among Russian sex workers in Moscow noted for example how in one instance a doctor at a public health facility used a pen to examine a female sex worker to avoid touching her. Such negative experiences with health personnel can be a determining factor for future health behaviour (Aral et al. 2003).

In a public health perspective there has been a strong focus on HIV/AIDS and STDs when addressing the health of sex workers (Sanders 2004, Ghys et al. 2001, Alexander 1998). This group is often referred to as a bridge population, which means the spreading of a concentrated epidemic into the general population (Ghys et al. 2001). With regards to HIV this happens if a client has unprotected sex with an HIV infected sex worker, gets infected, and passes the virus on to his wife and future children. Having a STD makes you even more susceptible to HIV transmission, and condoms are the best way to protect oneself from both (Ghys et al 2001). Still, there are many reasons that often compromise the negotiation power for sex workers to use condoms such as clients refusing it or that they pay more for

unprotected sex (Ghys et al. 2001, Alexander 1998). Therefore sex workers have often been the target group for a lot of HIV prevention programmes. Some have been rather successful like in Thailand where the government played an active part in making condom use the norm in brothels (Nelson et al. 1996). Other strategies have focused on peer education and outreach programmes (Chacham et al. 2003). Still, it has been pointed out that in the fight against HIV, other health needs of sex workers have been neglected. A study among Brazilian sex workers mentions how these women had complaints about chronic yeast infections due to vaginal creams, urinary tract infections and unhealthy practices related to their work for example using cotton to hide or block their menstruation in order to continue working in these periods. This practice resulted in abnormal discharge, chronic vaginal and cervical infection, pelvic inflammation disease and in worst case to hysterectomy. These health needs are often neglected in health interventions targeting this group, since these have been more committed to HIV prevention. At the same time the women had difficulties in accessing public health care facilities due to harassment and stigmatization (Chacham et al. 2007).

Another health issue related to sex work is violence and the fear of violence. It seems that young and inexperienced sex workers are more at risk than those that have been in the business for some time. It is not uncommon that sex workers develop different strategies in order to avoid violence from customers and that these strategies are learned and developed over time. Such strategies can be the screening of clients, the threat of a third party, escort and reporting systems of violent customers (Chacham et al. 2007, Sanders 2004).

Other physical health complaints that have been reported by sex workers themselves, but largely been neglected in a research perspective are musculoskeletal injuries, repetitive stress injuries to arms, wrist and shoulders due to repeated hand jobs, jaw pain, knee pain, foot problems because of high heels and back problems. Furthermore infectious diseases among sex workers are not only limited to STDs. Pneumonia, bronchitis, and tuberculosis are other reported health complaints, especially among street based sex workers (Alexander 1998). In addition to physical health needs many sex workers have mental health complaints. This relates to stress, depression, shame and the fear of being discovered and in some contexts arrested. In some instances sex workers also have strategies for avoiding mental stress, such as separating love and sex, certain parts of the body are off limits, and rules of no kissing (Sanders 2004, Alexander 1998). However the risk of being discovered or identified as a sex

worker are in some places considered as very stressing and difficult to control. Moreover, the risk of being associated with sex work always stays with the women, even when they leave the business (Sanders 2004).

In a Norwegian context studies that specifically examine health issues and sex work are lacking. The Pro Centre publishes a yearly report where statistics from their health clinic are presented and commented (Pro Sentret 2008). The Pro Centre has also published a report specifically focusing on the health promotion work conducted at the indoor market (Renland 2002), and a survey on violence and sex work (Bjørndahl & Norli 2008). However, health and sex work in Norway remains an unexplored research area with many unanswered questions.

2.3 Sex work in a Norwegian context

The Norwegian sex market can be divided into two categories; the indoor market and the street based market. The outdoor or street based market can be defined as selling and purchasing sex in the public sphere. While the indoor market is when sex is sold and bought outside the public sphere, like in massage parlors or private apartments (Pro Sentret 2009). The indoor market has been changing over the past decade and there has been a tendency that more and more women work alone from apartments. This way of working has been facilitated by the advertisement on different websites in order to attract clients. The shift from massage parlors to apartments has correlated with the police's actions against different indoor venues (Tveit & Skilbrei 2008a).

There are three major cities in Norway that can be said to have a street based sex market, namely Trondheim, Bergen and Oslo. Among these cities the market in Oslo is the largest in terms of numbers of sex workers. The composition of the Norwegian street based sex market has changed over the last years. Before the millennium the Norwegian street market was dominated by ethnic Norwegian women with substance abuse problems. This, however, changed in 2001 with the influx of Eastern European women into the Norwegian street based sex market (Tveit & Skilbrei 2008a, Brunovskis & Tyldum 2004). The Eastern European women generally operate on both the indoor market through advertisement, and on the street. Another characteristic of these sex workers is that they frequently travel back and forth

between Norway and their home countries, staying in Norway on a short-term basis. In general, this group is found to have high educational level, distinguishing them from several other groups in the sex market. The arrival of Eastern European women into the Norwegian sex market put a focus on female migration, and the reasons and organization of this process. In the research of these issues, special emphasis has been put on the question of organized crime, especially human trafficking (Brunovskis & Tyldum 2004).

In 2004 the arrival of a relatively large group of Nigerian women altered the Norwegian street based sex market again. This group established themselves in the market within a short time period in several major Norwegian cities; with Oslo having the greatest increase. The dominance of this group in the street-based sex market created a lot of attention and discussion, especially in terms of human trafficking and how or why this particular group of women came to Norway to sell sex. Consequently studies aiming at a better understanding of the Nigerian women's establishment into the Norwegian sex market were conducted (Skilbrei & Tveit 2007, Skilbrei et al. 2006), as well as research focusing on issues related to the migration process (Carling 2006, Skogseth 2006). According to the findings from Skilbrei et al. (2006) Nigerian sex workers were vulnerable in several ways. It was found that these women frequently lived in poor living conditions, such as living in run-down places and cramped together with a poor diet. They also perceived themselves to be at more risk in terms of violence and abuse, because their living situations and difficulties of getting a hotel room often meant that they had to accompany clients to their homes. Going to customers' homes makes these women more vulnerable as it is associated with more risk of violence and abuse (Skilbrei et al. 2006).

In Oslo the Nigerian sex workers were given a lot of attention due to the visibility of this group in specific areas of the city center. While other segments of the sex markets were confined to certain areas known for such activities, the Nigerian sex workers expanded the market to Karl Johan, the main shopping/parade street in Oslo. In addition they were also perceived as having a more aggressive approach towards customers (Jahnsen 2008, Skilbrei et al. 2006). The media coverage of the Nigerian women was extensive in the years 2006-2007, and sex work was increasingly seen to be a growing societal problem that needed a solution. At the same time the Norwegian government spent resources towards fighting human trafficking, by making their own action plans and creating specific groups within the police devoted to this matter (Jahnsen 2008).

The public debate on sex work became increasingly entwined with that of human trafficking, mostly due to the arrival of foreign women in the sex market, resulting in the view that sex work was a growing social challenge that needed to be controlled in some way. As the debate got more heated, demands for restoring social moral, order, dignity and justice grew stronger. One response to these demands was proposed in terms of criminalising the act of buying sexual services (Jahnsen 2008). Previously the government had seen social work as the best approach to handle difficulties faced by sex workers and sex work, however this was about to change (Skilbrei & Renland 2008). A criminalization of buying sex aims at changing both attitudes and practice, sending a message that buying sex is not acceptable. The element of punishment is seen as preventive, thus creating a decrease in the demand side of the sex market. In such a perspective the seller is seen as the vulnerable part and is therefore not prosecuted. In 2007 a law proposal for criminalising the act of buying sex was sent out on hearing to many governmental and non-governmental organisations. The comments were many and diverged, and the final proposition was sent to the Parliament 18th of April in 2008. Finally on the 4th of November 2008 the Justice Committee passed their law proposal to the Parliament, the result being that from the first of January 2009 it was illegal to buy sex in Norway. The punishment for this offense was fines and/or prison up to six months (Tveit & Skilbrei 2008a). The data collection for this project ended in December 2008, meaning that all interviews and observation was conducted while it was still legal to buy sex in Norway.

2.3.1 Services targeted at sex workers in Oslo, Norway

There are different services targeted at sex workers in Oslo, Norway. The most recognized of these is the Pro Centre which was established in 1983. This centre is financed by the Norwegian government and Oslo municipality, and offers a range of services to women and men that sell sex. The services include assistance with social and legal issues in the form of conversations with social workers as well as a lawyer. There is a specific section of the centre where people can sit and relax, eat food, use computers or laundry services. In addition, the centre also has a programme aimed at work integration such as Norwegian language classes and cleaning courses. The Pro Centre is also a national resource center on the issue of sex work, providing information and research material (Pro Sentret 2009, Tveit

& Skilbrei 2008b). Furthermore, the centre has an outreach programme, targeting both the outdoor and indoor market. The main activities for the outreach programme is to meet sex workers on their territory in order to hand out free material like condoms, lubricants, tissues as well as information about available services. This part of the service is seen to be an important health promotion strategy focusing on safe sex practices, as well as meeting and creating contact with sex workers (Pro Sentret 2009).

Since 2004 the centre has also offered health services to women and men that sell sex⁷. The focus of the health service is first and foremost aimed at reproductive and sexual health. The service is staffed with a doctor and nurses and consultations are mainly based on a drop-in system. However, once a week it is possible to book appointments with the doctor in advance. All the services offered at the centre are free of charge and registration at the health clinic does not require any legal documentation⁸.

The second most important organization offering services to female sex workers in Oslo is The Church City Mission, which is a private Christian foundation having several programmes aimed at different types of community work. The two facilities - directed at women that sell sex - are Nadheim and Natthjemmet. Nadheim was started in 1981, whereas Natthjemmet opened in 1990⁹. Nadheim is a drop-in centre offering different social services like individual conversations with social workers, help with practical issues and group activities like Norwegian language classes. In addition, Nadheim arranges a Women's Cafe once a week, where they serve free food and beverages. Nadheim also has an outreach programme targeting both the outdoor and indoor market. Natthjemmet is an overnight shelter providing women that sell sex or have experience with selling sex a place to sleep, wash and relax (Tveit & Skilbrei 2008b).

⁷ http://www.prosenteret.no/index.php?option=com_content&view=article&id=48&Itemid=62

⁸ Information based on observation and conversations with staff at the Pro centre, see also http://www.prosenteret.no/index.php?option=com_content&view=article&id=48&Itemid=62

⁹ http://www.bymisjon.no/templates/Page_2053.aspx Both of these services are confined to female sex workers.

2.4 Health behaviour framework

In literature on the relationship between individuals and health there is often a distinction between the concepts of health behaviour, health-seeking behaviour and health care utilization. Health behaviour has been defined as various actions taken by individuals who believe themselves to be healthy for the purpose of disease prevention or for detecting diseases at an asymptomatic stage (Conner & Norman 2005). According to this perspective health behaviour is understood in terms of prevention efforts. At the same time the term health-seeking behaviour has been used to explain the process of treatment seeking undertaken by individuals who perceive themselves to have a health problem (Mackian et al. 2004, Ward et al. 1997). Hence, this approach highlights different steps or determinants influencing how individuals obtain appropriate remedies or treatment. The concept of health care utilization has tended to focus on the end point of the treatment seeking process in terms of examining the usage of different health care services (Mackian et al. 2004).

However, a wider application of the term health behaviour has been proposed, which includes prevention activities, the process of treatment seeking and the usage of different services (Glanz et al. 2008). For example Kasl and Cobb (in Glanz et al. 2008: 12) have proposed three different categories of health behaviour; preventive, illness and sick-role. Preventive health behaviour is seen as individual activities carried out with an aim of staying healthy, and/or to avoid illness. Whereas, illness behaviour is when individuals identify themselves as ill, seek an assessment of their health status and search for a suitable remedy. Finally, sick-role behaviour is somewhat similar to illness behaviour, but highlights individuals' goals to get well and includes getting treatment from medical providers. In addition it also focuses on how being sick can lead to other behaviours, like not taking part in usual responsibilities (Glanz et al. 2008). In these categories treatment is not confined to medical providers, but also opens up for other treatment possibilities.

This study explores health beliefs, preventive behaviour, sickness behaviour, illness behaviour, the process of seeking treatment and utilization of health services. Hence, a holistic approach to the term health behaviour was evaluated as more pragmatic to avoid operating with various concepts.

2.4.1 Defining health behaviour as it is used in this project

In this project a broader definition of health behaviour has been assessed as more appropriate. Gochman (1982: 169) defines health behaviour as: “those personal attributes such as beliefs, expectations, motives, values, perceptions and other cognitive elements; personality characteristics, including affective and emotional states and trait, and overt behaviour patterns, actions, and habits that relate to health maintenance, to health restoration, and to health improvement”. The first part of this definition points to individual factors relating to the conception of health and health needs, and how these affect different sets of health related behaviours. In this definition health behaviour is viewed as preventive efforts taken by the individual, as well as what individuals do in search of treatment or well-being once they perceive themselves to be ill. Thus, this understanding of health behaviour also involves how and why people use different treatment opportunities.

The weakness of this definition is that it puts emphasis on the individual, not taking into consideration how external social or structural factors influence individual behaviour (Glanz et al. 2008). However, in this project it will be argued that health beliefs alone are not enough to understand or explain individuals’ health behaviour. Hence, aspects at other levels than the individual will be discussed in the analysis and discussion part of this thesis, pointing out how these can affect individual health behaviour.

2.4.2 The relationship between health beliefs and health behaviour

Beliefs can be considered as building blocks in the construction of meaning in our social world. In other words, beliefs influence how certain actions or decisions are seen as more significant or natural than others. Thus, beliefs can motivate or limit different behaviours. In the context of health, belief systems are central for how we define and evaluate our health and well being. In addition, they also affect how risk is conceived and how symptoms are interpreted. Hence, they are likely to be significant in determining what action should be taken, in terms of seeking treatment or prevention efforts.

The health belief model (HBM) is one of the first established theoretical models to explain health behaviour by placing an emphasis on individuals’ beliefs about health. The model was

originally developed in the 1950s by social psychologist in the US Public Health Service to explain why people did not participate in prevention and screening programs. However, the HBM has gradually been applied on other public health issues as well (Champion & Skinner 2008, Abraham & Sheeran 2005). The starting point of this model is the individual's recognition of being susceptible to a condition or a health problem. Furthermore this condition or problem must also be seen as having serious consequences. Together this constitutes what is termed as perceived threat in the model. In this model the individual believes that action is possible in order to prevent or treat the condition or problem in question. Whether or not an action is taken is dependent on what the model calls; perceived barriers and perceived benefits. These two categories are referred to as outcome expectations. It is believed that the potential benefits must outweigh perceived barriers in order for an individual to take action. This model has later on been refined to include the concepts of self-efficacy and cues to action. Self-efficacy is the individual's confidence in his or hers ability to take appropriate action, while cues to action are trigger mechanisms for actions, such as for example media publicity (Champion & Skinner 2008, Abraham & Sheeran 2005, Nutbeam & Harris 2004).

Even though the HBM can be used in terms of understanding adherence to treatment or choices of different treatment, it has very often been used on issues targeting behaviour change, such as safe-sex practices, overweight or screening for cancer. However, the HBM has proven to be most functional when applied to behaviours for which it was originally intended to, such as screening and immunization (Nutbeam & Harris 2004).

A major critique against the HBM is that the explanatory focus is at the individual level, it sees the individual as a rational actor. The model does not take into account social, environmental and economic factors which often present barriers to taking action. Furthermore, the HBM model do not include how social forces, like norms or power relationships between individuals influence health behaviour (Munro et al. 2007, Nutbeam & Harris 2004). When such factors come into the picture it is not always a question merely about the individual's beliefs or choices.

In this study the HBM has not been chosen as a theoretical framework, because of its focus on behaviour change. This model gives little attention to the origin of health beliefs and how these might differ across various social and cultural settings. For example, little

consideration is given to the stability aspect of health beliefs and what happens when explanatory models or beliefs change. In other words the model does not include the dynamic aspect of our social world. Furthermore, the HBM does not problematize how interactions with actors holding a different belief system can influence individuals' health behavior.

However, elements from this theoretical model are drawn upon in this study, such as; viewing the recognition and interpretation of symptoms, perceived threat or risk as the basis for health behaviour.

2.4.3 Health behaviour in relation to service utilization

Even though health beliefs should be seen as important in terms of how individuals act, there are also other determining and influencing factors. A critique towards models or research focusing only on health beliefs have been that this is seen as insufficient in explaining various determinants for the decision making process that individuals go through (Munro et al. 2007). In other words, all types of behaviour cannot be explained in terms of health beliefs alone.

Conceptual frameworks focusing on how people behave when they are ill and what choices they make regarding the use or non-use of treatment opportunities can be put into two broad categories; pathway models and determinant models (Kroeger 1983). Pathway models describe several stages of individual's decision-making in the process of illness behaviour. Different factors are identified at the various stages, such as predisposing factors (education, age, sex) need factors (symptoms of illness, perceived health status), and enabling factors (income, insurance, residence) (Pokhrel & Sauerborn 2004). There are several researchers which have contributed to the conceptual framework of pathway models and this framework consist of various models with different stages (Kroeger 1983). Qualitative method has been the main approach to this type of framework. Determinant models see a different set of explanatory variables or determinants as the basis for how people chose different forms of treatment opportunities. Studies using the determinant model approach have mainly been of quantitative nature (Kroeger 1983, Pokhrel & Sauerborn 2004). Regarding pathway models, the main critique have been on their lack of recognition of how social forces influence people's choices (Srebnik et al. 1996). Health behaviour in terms of service utilization has often been addressed as the individual's rational choice. However, as it will be discussed in

this thesis, behaviour is rooted in social relations, and these affect how one interprets illness and what action one takes or do not take. Moreover, deciding what treatment should be sought or what services should be used is a process. Hence, it contains a range of different decisions and not necessarily one single plan (Pescosolido 1992).

3. Methodology

This chapter covers the methodology of this project. Initially, the research design will be presented and the research approach will be defended. Thereafter, methodological issues related to the study site, access and participants will be described and discussed.

Subsequently, the data collection methods will be presented, with an emphasis on strengths and limitations. In the next section reflexivity will be examined, followed by a discussion on the trustworthiness of this study. Then, the ethical considerations for this project will be presented and debated. Finally, a short description of the method for data analysis will be outlined.

3.1 Research design

This research project is a qualitative study. The techniques used to collect include semi-structured interviews and observation. These methodological tools were applied on two different samples; one with service providers and one with migrant female sex workers.

The aim of this study is to better understand the health behaviour of female migrant sex workers in Oslo, Norway. The questions asked were of explorative nature, seeking answers to *what*, *why* and *how*. The focus of this project was to examine participants' beliefs about health and health behaviour, as well as reflections over the usage of different health services. The objective was not to assess their health status according to clinical definitions, or describe their behaviour by counting visits to health facilities, or quantify opinions or behaviour. Qualitative method was therefore chosen as the best method getting answers to the objectives of this study (Pope & Mays 2006a, Ulin et al. 2005). Moreover, qualitative method is more suited than quantitative when the research population is small and difficult to access (Basset 2004). In Norway the population of female migrant sex workers is small, and the sensitive and sometimes stigmatizing aspects of sex work makes this group difficult to access.

This study is informed by a constructivist way of inquiry. This means that the social world is seen as a construct of political, social, cultural and psychological context. The aim of such a

study is to explore the constructs, or social worlds, of participants in relation to health, and what implications these have for their health behaviour and interaction with others. In this study no single truth will be sought, rather different perspectives will be presented and discussed. In addition reflexivity will be addressed to show how I, as a person with different characteristics and experiences, have influenced the research process (Patton 2002).

3.2 The study site, access and sampling

3.2.1 The study site

The site for this research project was Oslo, Norway. Due to both ethical concerns and security reasons this project was done in collaboration with well established organizations and projects within the field, and the data was collected in cooperation with them at their different locations or outreach activities. In this study the Pro Centre and Nadheim were used as main collaborators, based on the fact that these two organizations are well known for their well-established and experienced work with both Norwegian and foreign sex workers in Oslo (Tveit & Skilbrei 2008b).

3.2.2 Access

Due to the sensitive and sometimes secretive nature of sex work, one of the project's early priorities was to gain access to the field. In the planning phase both Nadheim and the Pro Centre was contacted and asked for collaboration throughout the fieldwork. The staff at these organizations functioned as gatekeepers. Gatekeepers are people that can provide and facilitate access to informants and the study site (Rossman & Rallis 2003). Four months were spent with both organizations during the autumn 2008. In this time trust was built with both the staff at Nadheim and the Pro Centre, in addition, it functioned as a method to get a deeper and richer understanding of the field. By working together with these centers it was also easier to gain trust among the research population, as this collaboration was a symbol of trust and approval in itself. This made it possible to observe the research population in various settings as well as to have informal conversations with people in the milieu. Furthermore, the service providers introduced me to different places and people, as well as sharing their knowledge and work experiences. Being able to be present in various locations frequented by

the study's research population made the recruitment process less time and resources consuming.

An external challenge for gaining access was the political debate in 2008 on whether to make it illegal or not to buy sex in Norway (Tveit & Skilbrei 2008a). This discussion attained a lot of media coverage, especially focusing on foreign migrant sex workers and the organizations working with this group (Jahnsen 2008). As a consequence the organizations within the field used much time on analyzing and planning how to deal with the proposed law. The result being that the organizations did not have too much capacity to respond to various requests regarding their work. However, due to the fact that very little research has been done on sex work and health in Norway, the project was prioritized and given access by both Nadheim and the Pro Centre.

3.2.3 Research participants

Two samples were used for this research project; one with female migrant sex workers and one consisting of service providers for this group. The sample consisted of 12 participants from each group.

3.2.4 Inclusion criteria

The inclusion criterion for assistance providers in this study was first of all that they had some level of experience in working with female migrant sex workers in Norway. The participants had to be working within an organisation or a project that offers services to sex workers in some way. Since the collaborating organizations were decided to be the Pro Centre and Nadheim, participants were recruited from these. There was no requirement of formal education; however a mix between social and health workers was seen as appropriate to bring out the width and richness of this group's perceptions, experiences and reflections. In this sample the participants were of both genders.

The sample recruited for the group of migrant sex workers was female. One reason for that was that the majority of this population is female. Furthermore, a lot of the issues surrounding health, like health care needs and experiences, were linked to reproductive health needs of women such as pregnancy, abortion and menstruation. By including both genders it would make it more difficult to find trends and see patterns, since the sample initially was very small. There was no upper age limit for the participants, but a lower age criteria was set at 18. This decision was made on the basis of the Norwegian law which classify persons under the age of 18 as children. The women had to be in Norway on a temporary basis, meaning that they were not Norwegian residents, or formally living here on a long-term basis. This assessment was based on the operationalization of the term migrant sex worker. This was based on the fact that those that are residents in Norway, or for example live in the country as asylum seekers, are entitled to a different set of rights than those that staying temporarily as for example tourists. Another inclusion criterion was that the women had to be, or have had experience with, selling sex on a regular basis. Women who had not been actively selling sex for over one year was not eligible for this study. This was decided based on considerations of the accuracy of the data, since time naturally influence the accuracy of the information provided. The study was also limited with regards to the country origin of the women. Since the two largest groups of migrant sex workers in Norway are from Nigeria and Eastern Europe, it was chosen to focus on women from these areas.

3.2.5 Sample selection

Informants from the sample of service providers were recruited by me, and were selected on the basis of their assumed knowledge on the research topic. This is what is usually referred to as purposive sampling (Ulin et al. 2005, Patton 2002).

The sample of female migrant sex workers consisted of twelve informants, where half were from Eastern European countries and the other half from Nigeria. The age of the participants ranged from the early twenties to late forties. All, but one of the twelve informants were currently working, or had experience with street based sex work. The participant that was not

engaged in street based sex work, sold sex from an apartment through advertisement on the internet. All informants had been involved in selling sex in Oslo within the last year.

This sample was recruited in two different ways. Nine of the informants were recruited at the Pro Centre's health clinic. The recruitment was done on Tuesdays and Thursdays from the end of November until the end of December 2008. These days were chosen because they had evening opening hours, and generally more visiting patients than the other weekdays.

Potential informants were asked by the health personnel at the end of their consultation, and those that agreed were interviewed straight away. This sampling strategy is called convenient sampling and means that informants are selected mainly upon their availability to the researcher (Bryman 2008). This can be a good strategy when the research population is hard to reach and/or are in life situations that make it difficult to have scheduled appointments.

An advantage of this strategy is that it is less time consuming (Bryman 2008). In addition the health personnel asked all their patients during one shift, meaning that various types of informants could be approached and included.

Three respondents were recruited by the staff at Nadheim and they were chosen based upon their experience and assumed knowledge on the topic, or purposive sampling (Patton 2002). The staff at Nadheim arranged the interview appointments and they were conducted at the organization's premises, with the exception of one. An advantage of this was that informants had put aside time for the interview. However, this recruitment method meant that potential informants out of reach by this organization were excluded. In addition those women that had little contact with the organization were also less likely to be approached for participation. This recruitment strategy can also result in that the same persons are used frequently for research, as they are thought to be more talkative or representative.

Nevertheless, bias in sampling can be countered by recruiting informants from different locations and use different sampling techniques (Shaver 2005). Informants were therefore recruited from two different organizations that are thought to have contact with different groups among the foreign sex workers in Oslo. The Pro Centre is seen to have a majority of

Nigerian women using their services, while Nadheim has a closer contact with Eastern European women¹⁰ (Pro Sentret 2009).

One bias in recruiting informants through organizations is that one only reaches those in contact with these. The consequence being that the sex workers outside these services are not represented in this study. It is therefore important to have in mind that the findings from this study do not necessarily apply to those outside the reach of Nadheim or the Pro Centre. However, questions about other sex workers knowledge and behaviour were included in the interviews to gain some impressions and views about this group as well.

The media pressure and attention from the debate about the proposed upcoming law on buying sex meant that many women were afraid being identified as sex workers. This made it more difficult to recruit informants, and it was even harder when the law was finalized. Even though the law would not be in effect until January 2009, there was a lot of frustration and unease among the group as time came closer to this date.

Before the law proposal the recruitment process went on as expected. As Shaver (2005) points out it can be difficult to recruit informants when doing research on sensitive issues, hence many of the women approached for participation declined. This was an anticipated response and discussed with staff at the services. During one evening at the Pro Centre's clinic one or two out of approximately twenty patients would accept. However, when it became clear that the law would be a reality in January 2009 many more turned down the request to participate. By this time most of the interviews were done, but it was challenging to recruit the final informants. In practice this meant that several evenings were spent at the clinic, without getting any new informants. Other weekdays were also tried in order to see if this would make any difference, but it did not. Reasons given by potential informants for declining were that they felt they needed to work extra hard before the new law came and therefore had no time, or they were afraid that their identity would be revealed. Some also stated that they felt they were being "chased away" by the Norwegian government and therefore did not see the point in participating in this type of research project. The staff at

¹⁰ Based on conversation and observation with the two organizations.

Nadheim also reported that the women they approached, some initially positive, said they did not want to participate or did not have time. This was also due to the new law proposal. However after spending more time than initially planned for the recruitment of participants, the final interviews were completed.

3.3 Data collection methods

3.3.1 The qualitative interview

In qualitative method the researcher can use semi-structured interviews or in-depth interviews. Both have a loose structure and use open-ended questions, but the in-depth interview will be even more loosely structured and cover only one or two issues in greater detail (Bitten 2006). In this project semi-structured interviews were used, and one in-depth interview was done as a follow-up interview with one of the female sex workers. In total 24 qualitative interviews were conducted with two different samples. The interviews with the service providers were conducted first, as they were thought to bring up themes that could be used in the interviews with the sex workers. These interviews were also easier to start with as these informants were easier to access.

3.3.2 Interview guide when doing qualitative interviews

The advantage of open-ended interviews is that they give room for the informants to answer the questions in their own words thereby determining the information given. In this type of interview the participants will be stimulated to reflect over a certain issue or question posed by the researcher and this will be pursued with follow-up questions and probes (Bryman 2008, Patton 2002, Rossman & Rallis 2003). The interview is in other words an interactive conversation where knowledge is explored and reflected upon by the respondent and the researcher. It is however different from an everyday conversation since it has a structure and a specific purpose, and is in large parts controlled by the interviewer who decides the topic and initiates the interaction (Kvale 1996). Qualitative interviews can be conducted with the use of an interview guide. The interview guide is loosely structured and sometimes only consists of a list of topic or themes to be covered during the interview (Patton 2002). This

structure allows the researcher more flexibility during the interview as it allows the researcher to explore the respondents' views of their social world and themes as they emerge (Bryman 2008). Flexibility is especially an advantage when interviewing about a sensitive issue such as health and sex work. In the planning phase of the project an interview guide was made for both the service providers and the sex workers. Themes in the interview guides were based on the research objectives and reviewed literature. The interview guides also included examples of questions for each topic.

As the interviews proceeded there was a continuous need to revise the interview guides, by skipping or questions or adding new themes that were found useful or lacking. The sequence of themes and questions was also rearranged. One difference between the usage of interview guides regarding the two samples was that in the interviews with the sex workers it was more helpful to have prepared questions and a tighter structure. A reason for this could be that these interviews were done in a language not native to me and some of the informants, resulting in a less natural flow than in the Norwegian interviews. Questions and probes were therefore used as tools to create a flow as the interviews proceeded.

3.3.3 The usage of an audio recorder

All of the informants were asked to permit the recording of the interviews. When it came to the service providers there were no questions about this matter, in fact it was kind of expected. As for the interviews with the sex workers some had a mixed response to this request. This was mainly due to the misconception that the recorder was a camera, or that the informants were unfamiliar with this device. In these instances time was spent on showing how the equipment worked, by making some recordings and playing them aloud. The reasons for using the recorder were also explained in more detail, highlighting that they would only be listened to by me. After this demonstration all informants consented to the recording of the interviews. While it is recognized that the usage of an audio recorder can have a limiting affect on informants, especially when talking about sensitive issues (Bryman 2008, Patton 2002), it was not noticed that the recorder distracted respondents as they did not hesitate when talking or glancing at the recorder during the interviews.

In addition to using an audio recorder, notes were also taken during the interviews. This was done as a backup in case the recording could not be understood later on, or if technical problems like background noise occurred. Taking notes was also a way to write down facial expressions, body language and other information that could not be captured on an audio recording. This is usually referred to as tacit knowledge. These notes are also a way to contextualize the interview, and by comparing notes and recordings the dependability of the data for this study was be strengthened (Patton 2002).

3.3.4 The interview setting

Being aware of the context in which the interviews were done has been an important step in the planning phase of the project. It is important to reflect upon how specific contexts can influence the interview situation, as this can affect the data (Elwood & Martin 2000). All the interviews with the service providers were performed at their workplace and at a scheduled time. The interviews were done in Norwegian and took place in a closed office. Doing interviews at people's workplaces could prevent people from speaking openly and freely, as some might find it inappropriate to talk about their work experiences at this location, or have concerns about confidentiality of the information shared (Elwood & Martin 2000). Still, in this study there was no impression that this location prevented respondents from speaking freely and openly.

Due to ethical concerns and what is viable in practice, interviews with the female sex workers were chosen to be done at different locations where Nadheim and the Pro Centre offered services. This was a less timeconsuming strategy than making individual appointments to meet elsewhere, and due to the life situation of many of these women it can be difficult to remember pre-arranged dates or times for meetings (Sanders 2006). Moreover, the secrecy that often surrounds sex work, or the need for sex workers to keep their private lives separated, makes their homes a difficult, often inaccessible, location for interviews (Sanders 2006). Many sex workers are cautious about their identity being exposed and conducting interviews in a public, or unknown space could therefore create stress and discomfort. By doing the interviews in an environment known to the informant it was also hoped that this would give a sense of security and be more relaxing. In addition, this locality also offered the access to social workers and health personnel in case some of the respondents in the sex worker sample asked for assistance of this type.

However, one of the interviews with the female sex workers was done at the respondent's house in accordance with her own wish. This interview was also the longest interview among this group of respondents. The biggest difference between this interview setting and the other was that this was more personal in many ways. Being at someone's home brought me into a more personal sphere of the respondent's life, and this informant also talked more about her family and life situation than many of the others. The frame around the interviews done at the organizations' locations was somewhat more formal and impersonal. Still, it is difficult to evaluate what effect this settings had on the different informants. Some might feel freer to open themselves outside of their home with a person they do not share social relations with and that they might not see again. On the other hand, others might prefer to share information in a more personal setting as this can be a way of creating trust between the informant and the researcher (Sanders 2006, Elwood & Martin 2000). It would have been interesting to do more of the interviews at the informants' homes to see if there was a noticeable difference, but in practice this was not an option.

3.3.5 Language used in the interviews

English was the language used for the interviews with the female sex workers. Since the African sex workers came from Nigeria where English is the official language, no interpreter for these interviews was needed. Still, this type of English could at times be difficult to comprehend, especially if the informant spoke fast. However, the time spent in the field was a way to get used to this way of speaking English. There were also differences in how these women spoke about their health. In this respect it was an advantage to have been in the environment for some time and learning different terminology used by both service providers and sex workers, preventing misunderstandings and enabling the communication flow in interviews. Nevertheless, at times when the informant was difficult to understand, clarification was always sought by asking them to repeat or to explain in more detail.

Since the sample of female sex workers from Eastern Europe consisted of different nationalities, it was easier and less expensive to use English instead of finding individual interpreters or limiting this part of the sample to one nationality. In addition people working in the field also supported the notion that it would not be problematic to do these interviews

in English. Moreover there are many issues that need to be considered when using an interpreter when doing interviews on sensitive topics (Newbold & Willinsky 2009, Patton 2002). The issue of trust was especially regarded, and how the interview setting would be with not only one outsider, but two. To bring in an unknown interpreter could have made the informant less open and skeptical towards the confidentiality of the information shared, even though the interpreter would be bound by the promise of confidentiality. It was therefore decided to do the first interview with an Eastern European sex worker without an interpreter and see how this worked. If it did not work out, the question of using an interpreter would be reconsidered. During the first interview there were not many language barriers, and the language difficulties were mostly sorted out by rephrasing the questions or using additional body language. When there was uncertainty about whether the informant was correctly understood, the answer was repeated to clarify, or the respondent was asked to explain in more detail. Another tool used for this challenge was follow-up questions. All in all, no major language problems occurred so it was determined to conduct all the interviews with the female sex workers in English. Still, when doing interviews with a language not native to both the interviewer and the respondent there is always the danger of misunderstanding what is being said (Bryman 2008, Patton 2002). Throughout the interview process awareness was given to this fact, however in practice it was on some occasions difficult to avoid.

3.3.6 *Observation*

An often cited weakness of interviews is that they can only give you information on what people say they do, and not what they actually do (Green & Thorogood 2004). There is often a difference according to what people say they do and how they actually act, and observation is a good way of obtaining knowledge about the complexities of human interaction in social surroundings (Pope & Mays 2006b). When studying health behaviour it is therefore a good idea to combine interviews with observational method to obtain both types of data (Green & Thorogood 2004).

In this project observation was used as a way to gather information about the field and also to later compare this information with data from interviews. It was a good method for getting to know the social setting of the study in order to understand it more as participants do. By observing behaviour over a period of time I was able to make out patterns and trends of interactions as well as listening to what people said to each other in their natural settings.

This combination of information is not attainable through an interview or a focus group discussion (Pope & Mays 2006b, Ulin et al. 2005, Green & Thorogood 2004). This way of collecting data is a good tool in understanding how different events and circumstances can influence health decisions (Ulin et al. 2005). The type of observation used when doing research on sex work and health have been participatory in the sense that I have been a part of the field in terms of conversations, interactions and locations frequented by this group (Green & Thorogood 2004).

Since observation increased the knowledge and understanding of the research topic, emerging themes could be used and probed in later interviews. Due to safety reasons, areas frequented by sex workers and clients were approached in collaboration with Nadheim and the Pro Centre. Participatory observation was conducted at the various services offered by these organizations from the middle of September until the end of December in 2008. Activities included being in the reception area at the Pro Centre's health clinic, handling patient registration and giving out material like condoms, paper and lubricant. This was an opportunity to see how patients came to the clinic, in groups or alone, and how they responded to the organizational system of the clinic. Furthermore, it was a chance to meet members of the sex work community in a more informal atmosphere than the interview setting and gave the opportunity to have informal conversations. The informal conversations done in different localities were however only used to get a deeper understanding of the research topic and roles and intentions were always explained. Other activities participated in, that was arranged by the services, were Norwegian language classes, "Women's Night" and outreach work.

The outreach activities were conducted, by foot, in areas of Oslo centre known for their street based sex work activities, mainly focusing on the harbor and the streets often referred to as "Kvadraturen". However, due to the movement of some groups of street based sex workers to Karl Johan, the main street in Oslo centre, one of the organizations also included this street in terms of observation; that is they did not hand out any material at this location. The outreach work was conducted together with one service provider. The main goal was to approach sex workers in order to hand out free material, give information about the organizations and answer questions (this was done by the service provider). On these trips the service provider would make a short introduction of me and my project in order to

explain my presence in the field. Outreach work was, however, not used as an arena for recruitment, instead it was basically a method to observe and understand the street based sex market. However, this was a good way to meet many of the women working in the street, and getting the project introduced to the community. It was therefore a way to gain trust and access, as well as learning and observing how the services conduct outreach work in Oslo.

3.3.7 Observation from the inside and outside

Observation is often time-consuming as it usually takes time before the researcher is accepted by a group so that they feel comfortable enough to interact naturally (Patton 2002). The participant observation at the reception area at the Pro Centre's clinic made it easier to blend in as I had a certain task to perform and was a part of the clinic in one aspect. However, when using participatory observation as a method it is always a challenge for the researcher to balance the perspectives of being both an insider and an outsider. I was therefore self critical and analyzed observations in order to avoid personal bias. This corresponds with the argument about how to balance the role of being both an insider and an outsider put forward by Pope & Mays (2006b), Ulin et al.(2005), and Green & Thorogood (2004). In the beginning of the fieldwork observations were guided by certain themes that had emerged from previous studies or interviews with service providers. One main challenge was therefore to have an open mind so that the initial ideas and themes would not narrow the focus, thus overlooking other emerging themes or trends. Nonetheless it is important to remember that even though one is aware of his or her background and pre-understandings, what is being observed is ultimately done so through the lenses of the researcher (Malterud 2001).

In addition to participatory observation 15 consultations at the Pro center's health clinic were observed. The observations were between female migrant sex workers and different nurses working at the center. These observations were done once a week over a time period of three weeks. During the consultation I was sitting in one corner of the room with a notebook, not interacting with the patients and nurses once the consultation started. This was made clear to all parties before the consultation. However, in one instance a patient involved me in the consultation, addressing both the nurse and me. This was probably due to the fact that we had met on several occasions and had a relation. It seemed as though it must have been very unnatural for this patient to ignore my presence in that situation, even though she was asked

to do just that. This example shows that it is not always easy to be the objective observer in certain settings, especially when the setting is known to the observer and there are relations between those being observed and the observer. Furthermore, social relations and settings are dynamic and just by being present one is taking part and influencing that particular process (Corrine 2006). In the consultations I was an outsider entering a private meeting between a health worker and a patient. This might have influenced both the health worker and the patient to act differently. During these observations the nurses were observed in several consultations, thus giving more continuity to this side of the observation. The patients however were only observed at one consultation. Considerations like these were reflected upon when interpreting the observational data. It is important to be cautious when making assumptions, and one way of countering bias could be to compare these data with data from other sources such as interviews (Pope & Mays 2006b).

3.4 Reflexivity

In qualitative research the researcher is seeing the world through his or her perspective, thus influencing the whole research process (Rossman & Rallis 2003). To reflect upon how the researcher's background, characteristics and pre-understanding influence the research process is therefore very important. The researcher can never transform into another person, and that is not a goal in itself. However, a reflection upon oneself as well as how one's persona can be perceived and affects different contexts and social settings, enables the researcher to take possible bias into account throughout the research process. This reflection upon how a researcher influences the research process is called reflexivity (Patton 2002). In qualitative method the researcher is an active instrument in the data collection process and personal skills of the researcher will therefore be a determining factor for the outcome (Ulin et al. 2005). Factors that can influence the data collection process are personal characteristics like race, class and sex. Regarding some topics, especially those of a sensitive nature, it can be beneficial if the respondent and researcher are of the same sex (Bitten 2006, Ulin et al. 2005). Qualitative interviews as well as participatory observation are sensitive to the researcher's characteristics, behaviour, listening skills and ability to establish rapport (Clarke 1999). To avoid personal bias it has been important that I have addressed my pre-

understanding and assumptions to achieve the flexibility and openness required to do qualitative methods.

Regarding this research topic being female might have made it easier to access the group of female sex workers as an outsider. There are men working in this field and they seemed no less “popular” than their female colleagues, but being there as a researcher and not as a social worker or health personnel it probably was advantageous being of the same sex. In spite of all of the differences between me and the informants, we could both relate to how it is being a woman. This common ground might also have made it easier to talk about health issues related to our biology, such as contraception and pregnancy. For example one informant openly explained that she could not imagine talking to a man about personal matters, even if he was a social worker.

It was in many ways easier for me to relate to the service providers due to the fact that there were more commonalities in terms of language, educational level and cultural background. Regarding the informants from the group of female sex workers there were many more differences. For example we spoke different languages and had different ages and educational levels. In most cultures sex work is not socially acceptable and those engaging in this activity might therefore feel ashamed or devaluated by society (Skilbrei 2009). Since I was an outsider not engaged in sex work, this difference can have created a gap, thus influencing the rapport between the informants and me and the information shared. In addition, researching a topic such as sex work is challenging for the researcher on a more personal level (Sanders 2006). Some of the stories told could at times be provoking or touching. For example, when meeting a young woman my age, this led to reflections of a more emotional character. Furthermore, a lot of the women I met frequently told me how they started selling sex. I remember one time talking with a woman who told how she was so upset after her first client that she cried and felt horrible. Still, she said that she gradually got used to it and that it became like a routine, where she played a role in a specific setting. This got me thinking about my first days as a nursing assistant in a retirement home. I remember how I was so nervous about washing, changing and dressing these old people I had barely met. Nevertheless, after a couple of weeks this became normal and their bodies became neutral as I had a specific role in a certain setting. This made me reflect more about the nature of sex work on a personal level. Thus, several thoughts and impressions were

constantly being readdressed, shaped and reflected on. Therefore the research process was at times intense, and I also discovered that it was of great support to be surrounded by people, social workers and health personnel, that had been working within this field for a long time. In the beginning it was also quite foreign to be in an environment where sex was so evident and present; however it was at the same time very neutral and impersonalized. I several times found myself puzzled by how quick I got accustomed to handling condoms and lubricants in a very professional and clinical way.

Being present at the different locations run by service providers for some time before starting the interviews was also a conscious choice. This was done in order to attain another understanding of the field than what was obtained through literature reviewed in the planning phase of the project. This proved to be useful as pre-conceptions were both refuted and confirmed. In addition it was also a way of getting used to speaking about issues of a sexual nature, as it was a bit overwhelming in the beginning to talk about sex and condoms in a public setting with unfamiliar people.

3.5 Trustworthiness of the study

It has been argued that qualitative research should be judged or evaluated in another way than quantitative. Lincoln and Gruba (in Bryman 2008: 377-380) have stated the need for specific terms and practices to establish and assess the quality of qualitative studies. This would be an alternative to reliability and validity which is seen as the standard for evaluating quantitative research. The main critique of Lincoln and Gruba (in Bryman 2008: 377-380) towards using reliability and validity in relation to qualitative research is the underlying assumption of absolute truths about the social reality. Rather they argue for a focus on different perspectives and encourage discussion between these instead of searching for one singular truth (Bryman 2008: 377-380, Patton 2002). Therefore a different set of criteria for qualitative studies has been proposed. A proposed criterion by Lincoln and Gruba (in Bryman 2008: 377-380) is trustworthiness. The concept of trustworthiness will be adopted for this study, as this is said to be appropriate for qualitative research that aims to understand the social world of participants and how they explain and understand the physical world (Patton 2002). It is also a more common way of approaching the matter of evaluation and

assessment in studies within a constructivist perspective. Trustworthiness has four different criteria; credibility, transferability, dependability and confirmability.

First, credibility refers to whether the research has been conducted according to good practice and methodology (Bryman 2008). In this study methodological questions and ethical concerns were considered in every step of the research project, from the planning phase until the end of the fieldwork. Ethical considerations have also been a crucial part of the handling of the data material and the final presentation. The second aspect of credibility is that the researcher should submit findings to members of the social world that has been studied, in order to seek confirmation that it is correctly understood (Bryman 2008). Due to the fact that no contact information was registered for the sample of female migrant sex workers, unless they wanted to, and the mobility aspect of this population, it was not possible to conduct such checks. Regarding the service providers additional questions have been asked, but due to time limitations they have not been able to read through the findings or the analysed material. Nevertheless, triangulation has been used to enhance the credibility (Bryman 2008, Patton 2002). This has been done by comparing interviews and observations, to verify information. For example, regarding the interviews there is always the question of whether respondents are giving truthful information. It could be that people say what they think the researcher wants to hear or that they portray information according to their future interest or other motives (Clarke 1999). Moreover, it could also be that the informant does not remember what actually happened if asked about a specific experience. In this project special thought was given to this in regard to the localization of the interviews and recruitment of interviewees. Since the interviews were done at locations where free services were offered and respondents were asked to participate by service providers, it can have influenced participants to hold back information of a negative nature regarding these services. For example Brunovskis and Surtees (2007) noted how difficult it was for them to get respondents to openly discuss negative aspects of the services they were involved in due to what the authors refer to as a 'culture of gratitude'. This would mean that participants in this study, that are receiving services from the Nadheim and the Pro Centre, would have a high threshold for saying something negative about these because they fear that this would be seen as ungrateful.

During the participatory observation in the reception area at the Pro Centre's clinic it was often noticed that women complained about the waiting time for the doctor or nurse.

However, when this was brought up in some of the interviews the respondents rarely saw this as an organizational problem of the clinic, it was rather explained by these women's impatience and them coming late to the clinic. In this case it could be that this actually was the way these particular respondents viewed the waiting system at the clinic. On the other hand, it could also be that these women had negative views on the waiting system, but did not wish to express it since they were at the clinic and associated the research project with this service. In another instance, one sex worker was very dissatisfied with the services received through the organisations. However, the next time we spoke she had changed her mind and it was very important for her that I made a note of this. At one level this example shows that opinions are dynamic and not fixed, changing over time and space as new experiences are made. At another level it was also very significant for this woman to make me understand how happy she now was with the services and how important they were for her. This is related to what Brunovskis and Surtees (2007) discussed in their study. Nonetheless, such incidents or diverging information was always considered, and data were compared in order to verify or reject information.

Transferability means giving a thick description of the data and the findings, so that other researchers can assess the possibility of transferring this to others settings. It is not the same as generalization, as it is acknowledged that the findings are oriented towards the uniqueness of the specific aspect of the social world being studied. The findings from this research are specific to the context of this study, and the conclusions are bound by time and space. However, it is hoped that they will provide useful knowledge and insight on the issue of health and sex work that can be beneficial for others. Even though context differ, this study will highlight matters that can be useful in other, similar settings too.

Dependability is a parallel to reliability in quantitative research. Reliability is whether the same findings and conclusions will be arrived at if the study is replicated (Bryman 2008). In qualitative research this would be very difficult to achieve, since the social world is dynamic and impossible to freeze. Instead, dependability is suggested as a criterion for attaining trustworthiness. Dependability means that the researcher should keep complete track of all the phases of the research process and the data collected. In this way peers can act as auditors. Regarding this study all the different stages of the research process has been described and discussed in this part of the thesis as a step towards enhancing the dependability of the study.

Confirmability is the fourth criteria for trustworthiness. It is recognized that complete objectivity is difficult to attain in qualitative research, nevertheless the researcher should have acted in good faith throughout the research process. This means that personal viewpoints or values should not interfere and affect the study (Bryman 2008). One way of becoming aware of how one might affect research is through reflexivity (Bryman 2008, Patton 2002). In this study reflexivity has been a significant part of the whole research process.

3.6 Ethical considerations

This research project was approved by the Regional Committee for Medical Research Ethics Sør-Øst, Norway (REK Sør-Øst) and notified to Privacy Ombudsman for Research (NSD).

3.6.1 Informed consent

Gaining informed consent is extremely important when doing research (Goodwin 2006, Green & Thorogood 2004). Obtaining informed consent is not only to get permission or a signature on a paper, it is also crucial that informants wholly understand what they are agreeing to participate in. Moreover, it should be an independent decision and one should not try to convince, push or force people to be a part of a project. The participants should also be capable of making a rationale choice of whether to participate or not (Goodwin 2006, Green & Thorogood 2004). However, the notion of informed consent can be difficult, especially when dealing with informants that are vulnerable in some way or another (Green & Thorogood 2004). When recruiting through organizations it might be that some feel obliged to contribute, because they feel they need to “give something back”. Nonetheless, a general impression was that the service providers in this field were very concerned with protecting these women from pressure to take part in research.

In this study all informants were given information about the project by service providers and also given time to consider participation. Those that wished to do so, then met for an interview. Before each interview information was given about the project orally, and each participant was also given a written information letter (Appendix A and C). In this project

oral consent was used instead of written as the informants did not see the necessity in a written consent form.

3.6.2 Confidentiality

As a researcher you are obliged to uphold the promise of confidentiality. This means that information obtained during research should not be traced back to informants, or be accessible for others outside the project (Goodwin 2006, Green & Thorogood 2004). Respondents should not experience that other people confront them with what they said in an interview. In this respect it is important that respondents are aware that information given will be used for a purpose and that it can be used as quotations (Goodwin 2006, Green & Thorogood 2004). Still, the researcher should portray this in a manner not indentifiable with informants. Sometimes this can be difficult, as our manner of speech is in no way neutral (Goodwin 2006). By being honest about this aspect and the fact that confidentiality is sometimes difficult to maintain the respondent can have a more conscious choice when disclosing information.

The promise of confidentiality is also more problematic when you are doing research on illegal topics or in the “outskirts of the law”. If you witness a crime or obtain information about it you are supposed to report this. Still if a researcher should report these things then it would be impossible to do research on these kinds of topics and populations (Green & Thorogood 2004, Patton 2002, Huberman & Miles 1994). Besides the researcher is first and foremost a researcher and not an investigator for the authorities. However, if one is coming across information of such nature, the researcher has to make a choice of whether to uphold the promise of confidentiality or to report. In this study such dilemmas were considered early in the research process, for example on the issue of pimps or that informants might be here illegally. In this project all informants had some contact with service providers and were actively using those. The aforementioned dilemma did not materialize and the promise of confidentiality was followed and respected throughout the research process.

3.6.3 *Anonymity*

Altering the participants' names and other background information can seem like an easy and straightforward task to do. But this task can be complicated when the research population and area is small and transparent (Goodwin 2006, Green & Thorogood 2004). The population of female migrant sex workers in Oslo is not very large and this milieu can be very transparent for both them and service providers, as there are not too many actors that work within this field. Changing background information was done at an early stage in the data collection process and much consideration was given to ensure the anonymity of the research participants. Details given in the data collection process, such as names of people, places or locations were altered when transcribing the interviews. Moreover, names or other contact information of the informants was not written down. When using quotations from participants and writing about participants in the text, it was decided not to use pseudonyms. Instead they have been referred to as 'service providers', 'health workers', 'Nigerian woman/women', 'Eastern European woman/women', or 'woman/women'. This decision was made due to the size of the sex workers community in Oslo and the small number of actors within the field. To protect participants' anonymity no names are tied to certain quotations, as this can lead to associations on who is behind the artificial name.

3.6.4 *The researcher's role*

Qualitative research involves face-to-face communication and interaction between people. Sometimes a lot of time is spent with respondents and intimate thoughts and experiences are shared. When using participatory observation the researcher is a part of the participants' daily life. Interactions like these between people over a certain period of time can make it difficult to be clear about roles, such as researcher and respondent (Green & Thorogood 2004, Huberman & Miles 1994). It could easily be that the role as a researcher can be conflated with those of a friend, a therapist or a community member, and there is a fine balance between the different roles. The biggest challenge in this respect was to clearly state that this project was done independently of Nadheim and the Pro Centre. In practice this was not always straightforward, as participatory observation was done as a part of their routines by for example handling the registration of patients for the health clinic, serving food or handing out condoms. This has been noted by other researchers in the field of sex work. For

example Sanders (2006) tells how her roles were sometimes changing and difficult to balance. Sometimes she was a researcher, a sexual health worker or a friend. The challenges faced by Sanders (2006) are also true for this project. By participating in many of the services, I was also a “condom lady”, or a receptionist at the health clinic. Hence the issue of clarifying the role as a researcher was not always easy, practical, relevant or viable.

3.6.5 Do no harm

When doing research there is also the issue of risk (Goodwin 2006, Green & Thorogood 2004, Huberman & Miles 1994). For some being a sex worker can mean that they have had many traumatic experiences in terms of violence, and exploitation and a lot of thought is therefore necessary with regard to risk minimization. It is always important not to pressure the respondents to reveal sensitive information, knowing when to quit an interview and how to react if someone asks for help or gets emotional (Goodwin 2006, Green & Thorogood 2004, Huberman & Miles 1994). In this research project working closely with service providers was considered important in order to make sure that the informants were safe and followed up professionally, if needed. In two instances informants asked for help that was outside my area of expertise and in these cases assistance was found immediately. This would probably have taken longer time if the research project had been done without collaboration with these organizations. A worst case scenario could be that the assistance sought would not be conveyed at all, due to the mobility and difficulty in accessing many of these women. In another instance one informant also asked to have a service provider present during the interview. It seemed that the presence of a service provider she knew and trusted also made the informant more relaxed and open. Since both the informant and I knew the service provider, that person in a way created a safe relation between all of us, thus having a positive effect on the interview situation.

3.7 Data analysis

Qualitative fieldwork involves collecting data through interviews or observations. On the basis of these, new choices are made on what to follow-up, include or discard. In this way the fieldwork stage in a research process can be seen to be a pre-analytical stage, as the

researcher becomes more and more aware of patterns, qualities and trends in the material. The data analysis is thus an ongoing process, not only confined to the time period after the data collection is finished. However, when the data is collected it is natural that the researcher spends more time on a thorough analysis of the gathered material (Patton 2002, Malterud 1993).

In this study, data analysis was guided by Giorgi's phenomenological method as it is presented and discussed by Malterud (1993). The material was first transcribed and additional notes were added to the interviews to contextualise them. Afterwards the interviews were read through to gain a general sense of the material. Then the material was gone through over again with the aim of breaking it up into 'meaning units'. This means that certain parts of the material were focused on as they were seen to contain information on the objectives for this study. The parts of the material being related to the issues examined for this project were first put into broad codes. The text elements within the codes were compared to find a common meaning, which eventually led the codes to evolve into categories (Malterud 1993). This stage of the analysis process was done with the assistance of a text software programme called "Open Code". To avoid fragmentation the categories were evaluated according to the context they were derived from. In this thesis different text elements have been used as quotations for the purpose of illustration and documentation (Malterud 2001, 1993).

As pointed out by Malterud (2001) it is important to clearly state the type of framework used when analysing and interpreting data. Even though I tried to be open and let the data "speak for themselves" it must be recognized that all researchers are guided by theoretical standpoints and/or frameworks. As Malterud (2001:486) points out; "the theoretical framework can be equated with the reading glasses worn by the researcher when she or he asks questions about the material". As previously mentioned this study draws on a constructivist research philosophy, hence this has influenced the choice of theoretical framework and the following interpretation of the data. Even though it has been acknowledged that a health behaviour framework has had an effect on the process of analysis, no predefined categories or codes have been used.

4. Health beliefs and health behaviour

Beliefs relate to how humans position themselves to the social world around them, towards practices, events, persons or institutions. This positioning normally involves an evaluative dimension, such as whether one like/dislike, agree/disagree, and this is likely to affect one's behaviour and actions. Different social and cultural settings will form beliefs about health and also influence health behaviour directly and indirectly. However, social and cultural contexts differ across time and space. Thus, our social world is not fixed, but it is constantly changing. Different social and cultural settings will also influence how our health beliefs are interpreted and met by others, sometimes leading to confrontations or a reassessment of our own perceptions and beliefs.

This chapter will give an exploration and discussion of health beliefs and associated health behaviour among female migrant sex workers. This will mainly be based on the findings from this research project, and supplemented with existing relevant research. Initially, different perceptions of health and illness will be examined, with an emphasis on how this is interpreted and approached by Norwegian health care workers. Then a discussion on the need for focusing on mental health services for this group of sex workers will be explored, showing the many challenges inherent in this question. This is followed by an examination on how migrant sex workers view health risks in relation to selling sex, and how this is managed through various strategies. Finally, the topic of contraception and fertility will be addressed, showing how health beliefs, as well as social interactions and relations affect decisions and actions regarding condom usage, hormonal contraception and abortion

4.1 A meeting between different health beliefs

The service providers commented that there was a difference between the Eastern European and Nigerian sex workers when it came to how they used the health clinic at the Pro Centre. As they saw it quite a few of the Nigerian women had less clear reasons when coming to the clinic. They could come to the clinic with a running nose or a cough. While the Eastern European women were seen to have more defined needs, more frequently stating their

problems in terms of medical conditions and having certain expectations of what they wanted out of the consultation. Service providers discussed this difference in terms of how the two groups varied in their ideas about body, health and sickness. According to several service providers, the Nigerian women had a different perception of body and health, than the Eastern European women. As one nurse pointed out:

The Eastern European women might have more clear orders for what they want, like “I want a gynecological exam, because I need that, or I think I have a urinary tract infection, or a sinus infection”, so they are more specific in a way, they know what things are called, what they have or what they have had in the past, while a Nigerian woman might have more diffuse needs, they sometimes just have pain or they just want to check the womb or, yes, it’s more unclear, or they have less qualified knowledge about why they are here [at the clinic]. They experience having a health need, but they can’t quite identify it and they have a different conception of body and anatomy, a different physiology and different medicines, than what we have, and it is more [pause]. Yes, more unspecific and difficult to approach.

According to the service providers many of the Nigerian women had another way of looking at health, body and sickness. This was reflected in how many of these women expressed their health needs. The way these Nigerian women talked about conditions or symptoms was more foreign to the health personnel. For example the nurses had experienced that several Nigerian women had something which they called “toilet disease”. According to the women this was a sickness they got from sharing toilet facilities with others or using public toilets. This condition would give an imbalance in the vagina causing dryness, itching or discomfort. The health personnel rejected the idea of “toilet diseases”, telling their patients that it was impossible for them to get these symptoms from sharing toilets. They instead emphasized how some hygienic practices could create dryness or inflammation, such as vaginal douching. Among Norwegian health workers one can say that the biomedical discipline is hegemonic in how health and sickness is understood. Kleinman (1980 and Kleinman et al. 2006) makes a distinction in how medical physicians diagnose and treat *diseases*, while patients on the other hand suffer *illnesses*. Disease is in a biomedical perspective explained in terms of malfunctioning biological and psychophysical processes in the individual. Illness on the other hand is a representation of the personal, social and cultural reactions to

discomfort or health complaints. Culture is then a factor which shapes, influences and at times forms illness (Kleinman et al. 1980). As Ingstad (2007) also points out, how individuals understand illness depends on their cultural knowledge, previous experiences and how symptoms are reacted to and interpreted by other people in our social networks. In their cultural and social environment individuals learn “appropriate” ways of being ill (Kleinman et al. 2006, Kleinman 1980). Hence, individuals construct different forms of explanatory models. However, these models are not static and usually change according to new experiences made along the way of seeking treatment. In this way symptoms can be reinterpreted and other choices of treatment are made. Explanatory models are thus frequently complex reflecting different types of knowledge, where cultural or common beliefs coexist with those in the biomedical discipline (Ingstad 2007, Kleinman 1980). Still, the way certain illnesses are formed, explained and experienced from the patient’s perspective does not always coincide with medical physicians’ perspectives and beliefs. This can be especially challenging in a cross-cultural health care setting. It is important to note, that cross-culture does not necessarily depend on a large geographical distance, such as Africa-Norway, as social factors such as class, ethnicity and education also influence illness beliefs. Therefore variation in how sickness is explained, defined and coped with can be found in all societies (Ingstad 2007, Kleinman et al. 2006, Kleinman 1980). Nevertheless, the variation is likely to be experienced as more foreign, when the cultural and social context is more dissimilar, such as for example between Nigerian patients and Norwegian health personnel.

Since biomedicine has put little attention to the illness aspect of sickness, health personnel have not traditionally been trained to focus on the meaning of illness construction and behaviour in their patients. This can lead to a conflict between patients and health workers, as the first mentioned group might not want to follow the recommended treatment, because he or she disagrees or does not understand (Kleinman et al. 2006, Kleinman 1980).

Regarding the example of “toilet disease”, from a Norwegian health worker’s position this condition was diagnosed and framed in a biomedical perspective, drawing on established medical diagnoses and routes of transmission. From these women’s position however, “toilet disease” is not explained in a pure biomedical frame, but has its own explanation stemming from the sharing or using of public toilets. The meeting between the health personnel’s biomedical advice and the women’s health beliefs and practices was perceived as

challenging, especially from the health workers' point of view. The health personnel did not feel that their explanations were well received and it was difficult for them to give advice that would "sink in", or make the women change what they saw as harmful practices. This is how one Nigerian woman talks about her reason for going to the doctor due to vaginal complaints and the explanation she was given by the doctor:

[...]I was bleeding because I have itch, in my, itch in my vagina, so I came to report that I have itch, I don't know why, but doctor explained to me, maybe I wash too much up my private seat and caused it, I don't know, I say well, definitely maybe.

The doctor had previously taken tests to rule out STDs and the test results were negative. Still, the quote shows how the informant is ambivalent towards what the doctor says about her washing practices. In one way it seems as though she wants to believe the doctor's explanation. On the other hand, the washing is probably very significant for her, so she ends up in the middle, stating it to be *definitely maybe*. In this specific example the hygienic practice is confronted by saying that washing too much is seen as harmful and actually causing the discomfort. So even though the symptoms addressed are the same the explanation given by the doctor challenges a practice that is probably important to this woman. Research has shown how sex workers tend to wash their bodies excessively, as it is seen as hygienically important and having a symbolic effect of washing clients off their body (Chacham et al. 2007, Wong et al. 2006, Høigård & Finstad 1992). In addition, literature has also pointed to how these extensive washing regimes often include methods such as vaginal douching and using disinfections in the vaginal area (Chacham et al. 2007, Day 2007, Wong et al. 2006). However, in this quote it is clear that the woman absorbs the advice and information given by the doctor and takes it into consideration as a possible explanation for her discomfort. Since explanatory models are not fixed (Ingstad 2007, Kleinman 1980), this meeting could lead to a rearrangement of her explanatory model. On the other hand it could also be that her reasons for keeping up her washing practices are seen to be far more important, leading her to disregard the doctor's advice.

Another example on how the Eastern European and the Nigerian women were seen differently was also in terms on how they expressed pain. According to the health workers, most of the Eastern European women did not report pain as a health complaint. If they did it

was directed at specific body parts, such as back pain. Whereas the Nigerian women were perceived to frequently express different forms of pain, usually a general aching in their whole body. This pain was referred to as “body pain”. Sometimes the Nigerian women understood this pain to be caused by other internal conditions. As one of the nurses described it:

[...]They [the Nigerian women] can for example say; “the worm is biting me”, so they have an idea that when they experience bodily pain or are feeling physical discomfort it is because they have intestinal worms that bites them from within, and as a rule they do not have any worms. Worms, they are very much occupied with worms, that they have intestinal worms. It is probably more common in Africa, but very rare here, I have only experienced it once during the time I have worked here [...]

In the case of “body pain”, the health workers frequently found this to be an expression of psychological complaints like grief or sorrow, but that the women experienced it and felt it as a physical pain being situated in certain areas of the body. This condition was experienced as difficult to interpret by many of the health workers, as it was seen as different from how a Norwegian patient would express pain. In Kleinman’s (1980) work he gives an example on the meeting between a male Chinese immigrant and an American health clinic. In this example the male Chinese immigrant comes to the clinic presenting physical complaints; however the doctors cannot find any pathogenic cause. They instead claim that it must be psychological and refers him to psychiatric care, including psychotherapy and medicines. The man agrees to this, although reluctantly, because he did not identify himself with the psychiatric labeling of his diagnosis. During the treatment, the patient never accepted that he was suffering from a mental illness. He never told his family about receiving psychiatric care, since mental illness is highly stigmatized in Chinese culture. According to him the problems originated from “wind” and “not enough blood”, a physical disorder according to traditional Chinese medical terms. Kleinman’s work shows how patients can have very different explanations for their conditions, than clinicians. This is similar to the case of “body pain” in this study, as the women themselves and health personnel have different ways of explaining this condition. This can thus be an indication of how different sets of beliefs about illness and treatment are entwined and influence these patients’ health behaviour. In her study on Tamil refugees in northern Norway, Grønseth (2006) points to challenges and

difficulties that can arise when there is a mismatch between the patients' and health personnel's beliefs about health complaints and treatment in a Norwegian health care setting. The Tamil refugees in her study were accustomed to Ayurvedic medicine, or biomedicine that was sensitive to this tradition, where an emphasis is put on seeing the patient as a whole social person, thus giving room for a longer conversation about the illness experience. However, in a Norwegian health care setting this is not customary as there is often a focus on biomedical causes, not having a holistic approach to the patient's health. The result being that the Tamil patients felt that the Norwegian doctors did not understand them or were able to give them appropriate medical care (Grønseth 2006). In this study there are parallel findings that the health beliefs and treatments expectations were different between the Norwegian health personnel and some of their Nigerian patients. This often led to a frustration on the health workers' part when their advice or explanations were not accepted or understood by their patients.

However, the service providers in this study were trying to have a more culture sensitive approach, but were also careful about making cultural generalization and stereotyping. They underlined that the group of Nigerian women was not homogenous and they also experienced women from this group having a biomedical understanding and language when speaking about their body and health. They also linked the difference in perceptions about body and health as influenced by educational level and other social factors. Thus, the service providers were acknowledging the influence of social and cultural context regarding these women's health behaviour. In many ways they were trying to move towards an understanding of this patient group, as they pointed out they were gradually learning how to communicate through these differences in order to meet these women's health needs more adequately. The process of learning how to communicate cross-culturally was explained by one of the health personnel like this:

[...]You have to take it one step at the time and ask and ask and ask the first time to understand what this is all about. The first time someone told me; "I have a boil" I did not understand it, I did not know what a "boil" was. So you just have to learn these words like "boil" and my "blood is rushing me", instead of menstruation. You just have to learn these words and expressions by listening and asking and then you have to start using them [...]

As has been discussed here how we express ourselves in terms of meanings and symbols are tied to language. Nonetheless, language in itself can also be an obstacle to communicate health needs (Newbold & Willinsky 2009, Meadows et al. 2001, Bauer et al. 2000). In this study the service providers told that they sometimes experienced language as a barrier for communication. This was especially among the Eastern European women, since the Nigerian women spoke English. Still, a general comment was that the English spoken by the Nigerian women were different from how the health workers themselves spoke English. This was reflected upon by the health workers and it was clearly something they were conscious of when communicating with this patient group. As one of the health workers said:

[...]If I would have asked you “Your private parts, does it itch?”, then that would be a quite normal terminology, however this will not be understood, or many of our users from Africa will not understand it and then I have to ask them; “is it scratching you?” and they will understand. “Itching”, no, but “”scratching you”, this they will understand. So everything is like “it’s paining me, “does it hurt?” this they do not understand, if I am examining their stomach or something, “does it paining you?”, then they are following what I am saying.

As this quote illustrate the terminology used by many of the Nigerian women was being picked up and used by the health workers at the Pro Centre as a method of facilitating the consultation.

Regarding the Eastern European women the service providers pointed out that they had several among their staff that spoke different languages, like Russian or Bulgarian, and that they tried to use these when Eastern European patients or service users spoke little or no English. Due to practical constraints such as time and shifts it was not always possible to follow this strategy. In some cases friends acted as interpreters. This was seen as very negative, as illustrated by an example from a health worker:

Today I had a consultation with a girl that did not speak one word of English, not one word, but she had brought a girlfriend with her to act as a translator. This is not an ideal situation, especially when you notice that the friend does not function as an interpreter, because she sits there and decides what she wants to translate. For example when I started

to give information about our services, the friend just said; “yeah, but she already knows this”, instead of actually translating what I was saying.

Using friends or relatives as interpreters has been found to be a problem in other studies conducted on the issues of health needs and health behaviour among immigrants (Newbold and Willinsky 2009, Meadows et al. 2001). This was also the case for the health workers at the Pro Centre, as they underlined that this usually meant that a lot of information was bypassed by the translator. As these reflections shows the service providers were quite concerned with how they could best approach and facilitate communication to both the Eastern European and the Nigerian women. A tool to enhance communication through different languages and across cultures is cultural mediators¹¹ (Van der Helm 2004). The Pro Centre has used cultural mediators as a part of their work with migrant sex workers and they have cultural mediators from different countries such as Nigeria, Russia and Albania¹². Feedbacks from the health personnel regarding the usage of cultural mediators in consultations at the Pro Centre’s clinic were positive; nevertheless many consultations did not involve using these. However, the findings in this study regarding the challenges between different health beliefs, expressions and practices indicate a need for a more active engagement of cultural mediators in health matters. In this way, they can be a more efficient tool in aiding health workers to understand and examine social and cultural expressions, explanations and treatment expectations regarding health and health care. In addition the health personnel could benefit from training or lectures given on how to approach and deliver health service cross-culturally, also in terms of discussing their reflections, conceptions and experiences among themselves and with cultural mediators. As Grønseth (2006:93) says in her article: “attention is drawn to the need for health staff that is not only trained in cultural sensitivity, but also knows how to put such sensitivity into practice”. Findings from this project also indicate that more formal guidelines and training needs to be put in place for cultural mediators, as their roles and training were somewhat undefined. Nevertheless, it is important not to view the cultural mediators as stereotypes or keepers of a

¹¹ Cultural mediators are service providers from the same ethnic, cultural group or nationality as the migrant sex workers. They are thought to facilitate communication through interpretation of language and non-verbal codes. In addition cultural mediators are believed to have an important role in enabling a cross-cultural understanding of health and social issues. <http://www.tampep.eu/about.asp?section=methodology>

¹² http://www.prosenteret.no/index.php?option=com_content&view=article&id=12&Itemid=26

universal truth about certain patient groups, as this can lead to an ignorance of the individual patient's beliefs and expectations. As pointed out, there are different variations of health beliefs within all cultural and social communities (Ingstad 2007, Kleinman 1980).

4.2 Mental health – an undefined and unmet need?

Much research has focused on the psychological consequences of sex work, often arguing that there is an association between sex work and psychological distress (Chudakov et al. 2002, Farley & Barkan 1998, El-Bassel et al. 1997). Critics have stated that one should be cautious with equalling sex work with psychological distress or disease, as it can reinforce the social stigma by giving an impression that such behaviour will lead to mental distress or illness. In addition, sex workers are not a homogenous group and have very different experiences and social contexts before and during sex work (Vanwesenbeeck 2001). However, after initial interviews with service providers it became clear that they perceived mental health needs to be a major challenge in their work, both in terms of what they perceived as users' unmet needs and how to address these needs. The interviews with the female sex workers were then seen as an option to explore their views on this issue.

4.2.1 Perspectives on the need for focusing on mental health care

In this study one Eastern European woman spoke openly about the need for mental health care services in relation to sex work. According to her, sex work had created a lot of distress, making her unhappy with her own life situation. During the interview she expressed a wish for someone to talk to, and she stated that she did not feel she had a good social network:

Researcher: *Do you sometimes feel lonely?*

Respondent: *Always. I am dealing with many people in one day, I feel lonely. I feel like an animal. Of course I am lonely! If you are surrounded by people that mean [something], you not feel lonely, you feel more lonely when you are surrounded by a lot of people. Because these people just want, to take from you something and that's, they are not close to you.*

Researcher: *And how do you deal with that?*

Respondent: *Eh, I don't deal. I am suffering.* [She takes a deep breath, like gasping for air] *I find myself* [doing it again, gasping for air] *doing this, what that means, I suffer inside, I not relaxing, breathing bad, breathing deep* [sighing], *yeah, that means I am tired inside, I am lonely, I am not happy* [speaking in a low, serious tone]. *I am full of pain and problems and trauma, nobody understands.*

These feelings were exacerbated by this woman's lack of anyone to express these emotions to, and that she instead felt she had to smile and pretend when working the streets. This woman clearly stated that she wanted a service targeting mental health issues of sex work. She wished that there was a psychologist she could talk to, because she did not feel she could approach social workers or the health personnel at the services with these issues. She articulated her needs for psychological aid in this way;

They should have a psychologist and they should have psychotherapy in group. Because we got many traumas, many! And we have to heal this, how to heal? Speaking about, talking in groups, because we can exchange experience, we can heal our trauma, we can feel better, we are inside with all this pain.

On the other hand, she also pointed to the challenges that lie within the issues of mental health, and how in her home country going to a psychologist was relatively new and not socially accepted. According to her, there was little knowledge surrounding the subject of mental health, in her home country, and people often perceived psychologist as reserved for "crazy people".

The service providers had a very clear opinion that mental health needs existed among many of their patients and users. The health personnel especially discussed this in terms of what they saw as psychosomatic problems among many of their patients. According to them, this was particularly evident among the Nigerian sex workers. Typical complaints would be problems with sleeping, headaches, constipation and muscular pain in the body. However, a challenge mentioned by the health personnel was how to deal with these health complaints towards the patients. Many health workers said they usually tried to discuss the relationship between how difficulties in a life situation could manifest itself into physical problems. Still, most health personnel found these types of conversations to be difficult, as they felt they did

not reach through with their message to their patients. This is how one of health workers explained it:

[...]We can sit and talk for a while about how you [the patient] are far away from home and you miss your family. You do things you don't like, you are in a dark and cold country, where people express that they don't like you when you walk around in the streets, and all of this will make you feel pain somewhere in your body. And the patient will sit and nod and say; "yes, yes, I understand what you are saying", but when we are through talking and I feel there has been a breakthrough, the patient will say; "but what about medicine, I need a tablet so that the pain will go away". So they don't really have an understanding of the relationship between the mind and the physical body.

This quote shows that there is a conflict between how the Norwegian health personnel see these types of physical complaints being caused by factors such as stress and dissatisfaction within the women's lives, but that they themselves see it more as a medical problem best solved with tablets, such as painkillers.

Within the medical community there is an increasing recognition on how psychological distress can affect manifest itself through physiological conditions (Roy-Byrne et al. 2004, Malt et al. 2002, Lipowski 1988). This can be seen through proposals for moving beyond a biomedical model towards a biopsychosocial model, where social and psychological factor are incorporated into the understanding of disease and illness. In this model a greater emphasis is put on the patient's perspective and social environment in relation to illness experience (Borrell-Carrió 2004, Engel 1989). Such a perspective opens up for an association between the social setting and the individual's experience of illness and symptoms. However, it is still framed within a biomedical discourse, and the relationship between physical complaints and psychological distress have also been labeled and categorized into a state of disease or diagnosis. Hence, a health complaint, such as muscular pain, where a physical cause cannot be found is usually referred to as somatization. Lipkowski (1988) defines somatization as; "a tendency to experience and communicate somatic distress and symptoms unaccounted for by pathological findings, to attribute them to physical illness, and to seek medical help for them". The belief of somatization has become more and more acknowledged within the medical community, also in a Norwegian health

care setting (Malt et al. 2002). The reference to psychosomatic conditions among the service providers must be seen in light of this. However, the somatization approach was not well-received by many of the patients, as they were more interested in medication relieving the symptoms, not addressing what service providers saw as the real cause of the problem. The service providers expressed frustration over handling what they saw as psychological health complaints through medicines. Yet, this was the only tool at their disposal since there is no psychologist or psychiatric nurse offered as a part of the services.

There can have been many reasons why there was a disparity between how the service providers and how the Nigerian women approached the issues of muscular pain, constipation or headaches. One reason could be that they did not want to talk about their private feelings or thoughts with health personnel. Studies conducted about sex work often point out how sex workers have different strategies for distancing themselves from sex work (Day 2007, Skilbrei 2007, Sanders 2005, Høigård & Finstad 1992). If sex work is still a part of one's life it can be particularly difficult to reflect over how this might affect one's well-being or physiological health. One protection strategy would then be to "close the door" and ignore approaches aimed at this. Another reason could also be that it would be foreign for these women to share such private thoughts and feelings in a health care setting, since it might not be considered as being part of a health problem. Furthermore, it could also be that these women for example saw pain or constipation as a symptom of a physiological condition, requiring a diagnosis and medical treatment. Studies has shown, that due to the stigmatization attached to mental illness in many cultures, minor psychiatric problems are frequently manifested through physical symptoms (O'Mahoney & Donnelly 2007, Kleinman et al. 2006, Kleinman 1980, Grønseth 2006). A different explanation could be that these conditions were an expression of distress, but that their way of coping with this was solved in part by taking medicines, even though the explanation cause was not seen to be physiological. All in all, a more thorough exploration of what these bodily conditions symbolize and what they are an expression of needs to be carried out, before interpreting it as a psychosomatic condition where psychotherapy is offered as a solution. This is not rejecting the idea of a focus on offering mental health services as a part of services targeted at sex workers, it is rather an argument for gaining more knowledge about what these conditions represent for these women. Since health beliefs is thought to be the basis of health behaviour, it is vital to address what these beliefs consist of and how these are thought to be dealt with

from the perspectives of those experiencing it. Kleinman (1988) points out how bodily complaints can be symbols of different forms of distress, such as individual, social and political. However, the categorization and labeling of illness, its cause and treatment differ across cultures, also among Western cultures. For example, in some cultures depression might not be labeled as an illness category, and grief and sadness can be expressed very differently across cultures and societies (Kleinman 1988). It is therefore important to be sensitive to these sex workers' worldviews regarding their illness or symptom experiences.

In this study none of the informants brought up the issues of muscular pain or constipation as a central theme, they would instead say that they occasionally felt pain as a consequence of working hard. Nevertheless, this is not necessarily saying that the conditions noted by the service providers as psychosomatic are not common among this group of women, as it should be remembered that the service providers' experiences are based on countless interactions and consultations with this groups of sex workers over a longer time period. It could rather be that the women in this study did not feel comfortable bringing it up in the interviews or that the particular women represented in this study did not see this as a major health complaint. However, many of the female sex workers in this project brought up the issue of difficulties with sleeping where headache was an associated consequence. Since problems with sleeping can be a manifestation of mental distress (Strine & Chapman 2005), it will be discussed in the following section.

4.2.2 Sleeping and thinking

Several of the informants mentioned that they had problems in relation to sleeping. At one level it was explained in terms of their lifestyle, such as working from evening until early morning. Some also said that few hours of sleep often resulted in headaches. Nevertheless, another reason for having difficulties with sleeping was explained by what informants referred to as *thinking*. This occurred when they were alone trying to rest or sleep. When asked what they were thinking about, the informants answered that they were thinking about money and they expressed how these thoughts would influence their mood and feeling of stress.

In sleep, so when you are sleeping and problem, when you are thinking you have problem in sleeping, or in some way you are not so happy there, you don't sleep easily, problem when you want to sleep, because you have to think about the place so, that's it. Or when you go to the work, the street, you have no money, two days-three days, you come home, you are not gonna sleep and will start thinking, so it's like, that's it.

The thoughts about money were often connected to the economic responsibility many of the informants had for their families. It is not uncommon that female migrant sex workers have an economic obligation to their family members at home (Tveit & Skilbrei 2008a, Skilbrei 2007, Brunovskis & Tyldum 2004, Chudakov et al. 2002). Informants spoke about their need to take care of their families economically and the *thinking* often revolved around how they could meet the duty of financial provision for their families. One informant who had recently stopped working in the streets told how she had had continuous problems with sleeping and headaches when she was a sex worker, and she related this to the pressure of always trying to earn enough money for her family. However this had changed after she found a different job. The reason she had stopped working in the streets was that she had earned and saved enough money to secure her child's future and her family back home. She explained how she now felt she could focus on herself and her life, because she had arranged for the financial security of her son and family. In addition, this woman reflected upon how she thought that selling sex had impacted her as a person:

[...]before I don't was [pauses], this was first time in my life when me work in the streets, in other country I don't work, I was working first time here in Norway and, sometimes, you know, I don't was me, because I was very cold with the people, not friend, I feel this customer is not my friend. No and I was cold, I don't give too much important, not talking too much, ten minutes maximum, after go, you know, and before I stay, I talk, I laughing, I was, yeah [pauses and is quiet, indicating that the streets made her act differently].

When asked about if they sometimes spoke with health personnel at the Pro Centre about their difficulties with sleeping or thoughts, informants replied that they did not perceive this as a part of the health personnel's job. It was not seen as a sickness or health problem, but it was rather their own problem that they themselves should sort out:

No, normally I have not done so no [told health personnel about difficulties with sleeping], because I believe it's, it's normal, because I was thinking, it's when you think too much you think and the night is, you are thinking in the nights; it's very difficult for you to fall asleep, because you hate this life, turning around [shows how the body is turning at night], you cannot sleep.

This reflects the difficulties that surround offering a mental health service. The informant expresses problems with sleeping, because of thinking. She additionally states that she hates her life, or this lifestyle, and sees this in direct relation to not being able to sleep. According to this woman, having problems with sleeping was nonetheless classified as normal. It was perceived as a problem, but the thinking in the night was not categorized as something which belonged in a health care setting. It was rather something this woman had to live with and normalize. It is thus an indication of how the service providers' approach about opening up for including such issues in a consultation setting, might contradict some of these women's expectations and beliefs regarding these matters. Hence, how people perceive difficulties in life and their association with sleep difficulties and headaches will influence how these are dealt with. It is here the social context surrounding the individual comes into the picture, as it might be that it is more natural to share these issues within social networks.

Regarding communication within social networks, there was a difference among the Eastern European and Nigerian women. Most of the Eastern European women said that both talking about health in general and difficulties in relation to thoughts or customers was considered as private and personal. Several of the Eastern European women mentioned that they did not have close friends and that they were here alone, or just had one friend they trusted and confined in. More Nigerian women said they often talked to each other about health, such as where and when one should seek medical care. In addition, they more frequently referred to other women in their social network as friends. When talking about negative episodes with customers the Nigerian women stated that they would discuss this with their friends, often getting support and sharing similar experiences. Social support and social integration are thought to have a positive effect on individuals' capabilities in handling difficult situations and emotional stress (Cohen 2004), whereas loneliness and social exclusion are found to

have the opposite impact on mental health (House 1988). Studies conducted among immigrant populations have found social support to be an important contributor to mental health (O'Mahoney & Donnelly 2007, Li & Browne 2000, Cheung & Lin 1999). Due to the migration aspect of the group of female sex workers in this study it is important to examine to what extent these women have social networks providing them with social support, and how this affects their mental health and well-being.

In this study it was found that female migrant sex workers from both Nigerian and Eastern Europe had difficulties with sleeping, and the stated reason about economic obligations was similar for both the Nigerian and Eastern European women. Reflections regarding how sex work had implications for one's emotions and personality was mentioned by two informants from Eastern Europe, still it was only one of the women that said this with explicit references to a need for psycho-therapy.

At the same time, service providers experienced that many Nigerian women came to the Pro Centre's clinic with health needs that they could not find a physical cause to. Understanding the meaning of these bodily conditions is therefore a crucial starting point regarding interventions focusing on solving these health complaints. In other words, a greater emphasis should be put on how these conditions are interpreted by the women themselves and what they represent in their social and cultural context (Klein man 1988, Kleinman 1980). Without understanding the health beliefs regarding these expressions of pain, headache or sleeplessness, it is difficult to find appropriate responses and possible treatments.

Coping strategies, also in relation to social networks, needs to be examined as social relationships are found to be positively correlated with better health and well-being (Cohen 2004, Berkman et al. 2000, House 1988). Furthermore, how social relations interact with health beliefs can also give valuable insight into health behaviour (Kleinman 1980). Staying in line with Kleinman's argument, it is important to move beyond the biomedical model, moving towards an approach where the meaning and context of illness are taken into consideration.

4.3 Ideas and perceptions about health risks and sex work

All of the sex workers had a perception of sex work as being potentially risky for their health. It was perceived that risk could be minimized by protecting oneself, by using condoms, and paying close attention to one's health in terms of check-ups and blood tests. Hence, the majority of the women stressed the importance of testing themselves regularly as a consequence of selling sex. However, few of the informants mentioned diseases they wanted to be tested for by names; they rather said they wanted to check for everything to be sure that they were okay. Those stating what diseases they wanted to test themselves for usually mentioned HIV/AIDS and some informants also mentioned hepatitis and syphilis. This coincided with the service providers' experiences that the language for infections or diseases was rather limited among the majority of their patients. Renland (2002) also supports this through her research on health promotion on the indoor sex market in Norway.

The risk aspect of sex work was perceived as emanating from the customers. Many of the women described clients as being dirty and that they avoided touching them. One informant also said she preferably used gloves when touching the clients' private parts. In other words, all types of physical contact with customers were seen as potential risk factors for getting an infection. Even when clients appeared clean there was always an element of uncertainty as this informant says:

[...]because I have, was several times scared, different customer, you know, and they can be clean body and clothes, but never know, yes, if they have something [a disease], yes and for that I go [to have regular blood tests and check-ups].

As this passage shows contracting illness was associated with transmission from clients. Protection, in the form of condoms and frequent blood tests and gynecological exams was therefore essential for staying healthy and clean. In other words avoiding health risks were seen to be an individual responsibility. This is underlined by describing the customer in terms of uncertainty and risk underlining the importance for the individual sex workers to guard and protect her health from this. As in this study, Sanders (2005) found that sex workers frequently undertook health checks and preventive measures as a way of being responsible for their health. Furthermore, Sanders (2005) found that health risks were seen as

an issue more controllable than other aspects of selling sex. A similar conclusion can be drawn in this study as the women were very much occupied with checking their health and an expressed desire to stay healthy.

Avoiding physical contact from customers relates to drawing borders and barriers around one's own body. It is therefore not only a protection strategy confined to external threats of sickness, but also functions as an internal protection strategy. In this way the women are protecting their inner selves, by enforcing external borders and avoiding contact. This finding is consistent with a lot of research focusing on sex workers' different protection strategies. It is noted that it is common to have certain bodily parts that are off limit, as well as using physical barriers, such as gloves or condoms to avoid intimate contact with customers (Day 2007, Sanders 2005, Warr & Pyett 1999, Høigård & Finstad 1992). This strategy for creating distance to clients has also been found to be a way for the women to feel in control over their bodies (Sanders 2005). Hence, the maintenance of these strategies or rules is thought to have high priority. However, the emphasis on the no-touching rules can come into conflict with health prevention strategies regarding disease transmission. For example one woman told that she did not want to touch her clients, and that she therefore put on the condom differently than how the health personnel had showed her:

[...] this nurse, can show me, you can put like this, like this, but I'm not comfortable because when put like this [show how the condom is placed at the top of the penis], then down, I can touch [the client's penis], but I don't want to touch [giggles], I cannot like this, not touch with fingers [...]

In this case, the woman gives priority to the rule about no-touching of clients, putting advice from health workers secondly. However, such a practice is likely to increase the risk of a condom bursting or breaking, which puts this woman's health at risk. Still, it is evident that the interviewee clearly knows how to use a condom in a correct way, and she also acknowledges that she prefers using it differently, because she cannot touch her clients. So, when addressing how risk is managed and conceptualized by sex workers, health promotion needs to move beyond the focus on conveying safe sex messages in a proper and understandable way. It is just as important, if not more, that health workers and health promoters explore and understand the cultural, emotional and social environment in which

sex workers manage, perceive and address risk. As shown here, and also argued by Sanders (2005), emotional risks can be more pressing than perceived health risks.

4.4 Perceptions on contraception and fertility

4.4.1 Condom usage

It was only one informant who openly talked about how she sometimes did not use condoms with clients; all the other sex workers stressed the importance of always using a condom when working. However all the sex workers that were interviewed had experienced clients asking them for sex without condom by offering to pay more. This coincides with findings from several other studies focusing on sex work and condom usage (Sanders 2005, Bucardo et al. 2004, Vanwesenbeeck 2001, Cusick 1998, Waddell 1996). According to the women, such an offer would typically be met by this response:

[...]if he say I have to do it without condom, that he's going to pay me BIG money, I will think that I want to save my life instead; you don't want to use condom, so you get out. So that's it, because I don't know if he has sickness.

This reflects how the women saw their health as being more important than money, thus declining such an offer. Additionally, condoms have been found to have a double significance for sex workers. They protect against infections, but also create a physical barrier between the sex worker and the client (Day 2007, Sanders 2005, Waddell 1996), Høigård & Finstad 1992). As discussed in the previous section of this paper, creating distance has been found to be an important strategy for managing sex work (Day 2007, Sanders 2005, Waddell 1996, Høigård & Finstad 1992). This substantiates the finding that the sex workers were insistent on condom usage with clients, turning down offers to do it without. During the field work one of the service providers confirmed the notion of condoms having double functions. She told that many girls asked for black condoms. The service provider had initially thought that these were used when women worked during their menstruation; however this was only part of the explanation. The other reason was that the black condom prevented the sex workers from seeing the client's penis.

Most women had usually heard rumors about other girls who went with clients without condoms, but they were always outside their own social networks. Attitudes towards girls working without condom were viewed as a flaw of the individual woman and it was seen as a negative attribute of her personality. Girls that did not use condoms with clients or were tempted to drop the condom due to money were seen as stupid, described as giving in to temptation, as one of the sex workers said:

They [the clients] can deceive them; "I will pay you four thousand, three-five thousand", maybe those who are stupid say; "it's okay, let me count the money", like that, but the clever ones, I don't think they will do it.

When talking about condom usage with clients informants did not address the bargaining process, or the power relationship between sex workers and clients. Rather it was portrayed as if the power of this situation and choice lay solemnly within the sex worker. They were the ones making the decision to keep or drop the condom, were the latter was clearly viewed as wrong. This can reflect social norms inherent within the sex worker community. It was very clear that condom use with clients were seen as a norm, as reflected in the quotes above. Women that do not abide by the codes are described as weak or displaying immoral values, such as greed. Rumors and gossip about girls dropping the condom with clients can be seen as an example on social sanctions and expressions of perceived disrespect. Sanders' (2005) work supports this, as she also found that the sex workers in her study had clear moral norms, such as condom usage with clients and fixed price codes. Høigård and Finstad (1992) also found the same tendencies among Norwegian sex workers. The breaking of these social norms resulted in several repercussions. In addition, it should be noted that condom use is a highly normative issue within the broader community, especially since the last decades have put safe-sex practices and prevention of STIs and HIV/AIDS on most agendas over the world (Day 2007, Vanwesenbeeck 2001, Waddell 1996). This probably influences how moral codes are constructed within the sex worker community, but also how certain moral codes are given more attention and significance when speaking with outsiders. Hence, it becomes crucial to underline the importance of condoms, while the threshold for admitting to non-use will be very high.

Little attention was given to the client in the discussion about condom use. His demand for sex without condom was instead reduced to stupidity resulting from lust. The client was not described as weak, selfish or lazy, but instead references were given to how men argued for this service due to the wish for greater sexual pleasure:

[...] the men when they get [sex without condom], oh, they are stupid. They don't think it is dangerous, they just think about pleasure. How to get more pleasure and condom is not giving one hundred percent pleasure. They are crazy to do that, and they know you are in this business. They like to do many, many things without condoms! They do not care and they are, some of them are very lonely persons and very crazy for sex and they don't think about disease and not healthy or dirty, they don't think!

Even though informants expressed negative attitudes towards this request from clients, there was no display of a deeper normative questioning of the clients request for sex without condom. Instead it was reduced to foolishness and that the sex workers themselves had to point out potential negative consequences of this action. In this way the sex worker is represented as the guarder of good moral, teaching and shaming the client for his risky request. At the same time it also portrays the women as powerful and displaying self-efficacy over their own bodies. The need to display power over one's health can be especially important for these women, since there might be other sides of their lives that might be perceived as more difficult to control. This is in line with Sanders (2005) findings where women found health risks to be an area where they could exercise power and control. Condom usage was therefore seen to be an individual responsibility when selling sex. In this way the insistence of condom use and the negative portrayal of men can be important constructs to pursue a strategy of self-value, respect and empowerment.

The sex worker that spoke of giving services without condom explained it in terms of fear for losing clients. She claimed that her reason for doing it was not only that she was given more money, but that it was also a way of keeping the customers. This was how she described the situation:

They ask, they talk before you do something. You dealing with customer, you talk, they ask you to do this, to do that, you say yes or no. So they are open and they know exactly what they want. If you not accept, they say; “okay, bye”.

This woman said that if she did not agree to clients' requests they would just go and find somebody who accepted their offers. In this context condoms usage is explained in terms of competition for clients and a need for earning money. In this situation the customer is seen to have the stronger card, being able to take his business elsewhere if rejected. In this picture the sex worker finds it difficult to say no, as competition from other girls and the need for money makes her take a decision of not using condoms. This coincides with other literature that has been written on sex work and negotiation power over condom use (Wong et al. 2006, Bucardo et al. 2004, Wojcicki & Malala 2001, Cusick 1998). Furthermore, this woman claimed that others also did this occasionally. However, due to the normative tensions surrounding this subject they would never admit it. In her opinion, a lot of the condom accidents the health personnel dealt with, were just excuses used by sex workers to avoid telling the truth, due to shame and fear of moral repercussions. The fear of telling health workers about not using condoms with clients has been noted in other research (Day & Weber 1999). This shows that condom use with clients is a complex issue, where sex workers navigate through moral codes within the sex workers community, a feeling of control over one's health, and aspects such as economic pressure. The hierarchy of factors is not necessarily fixed, as economic needs might sometimes forego moral codes. However, as shown here admitting to non-use of condoms is perceived as wrong and is therefore kept secret.

The health workers however said that according to their experience the sex workers were very concerned with using condoms when working. This perception is consistent with other research which has found sex workers to be very insistent on using condoms with clients (Day 2007, Sanders 2005, Jeal & Salisbury 2004, Vanwesenbeeck 2001, Warr & Pyett 1999, Waddell 1996). In this study, all the sex workers except one said they always used condoms with clients. Nonetheless, the service providers stated that some user errors could exist, the most frequent being the usage of two condoms instead of one. This impression was confirmed in one of the interviews with the sex workers, where one woman explained her

reason for doing so: *I attach two, I put them together, cause I have to protect myself. Maybe the condom can have a hole, I don't know, so I put two.*

When using two condoms like this example shows there is a greater chance that the condom breaks or tears due to more friction created between the two. Using condoms wrongly, such as tearing due to nails, or putting two instead of one, has been reported in other studies as well (Chacham et al. 2007, Bucardo et al. 2004). Condom breakage, or “accident”, was something that most of the interviewed sex workers had experienced and is a common reason for wanting blood test and gynecological exams according to the health workers. Among the health workers, condom accidents were seen as a result of wrong usage, but also as a consequence of being engaged in commercial sex. As one of the service providers put it: *They are sexually active and they have a lot of sex. Naturally, a larger percentage in this group will experience condom bursts than in the general population [...]*

A general impression among the service providers was that while the sex workers were committed to using condoms with clients, this practice was altered when it came to their regular partners. As one of the service providers said:

[...] They use condoms with customers, but not with their boyfriends. This is because there needs to be a distinction between the boyfriend and the clients. It is usually the boyfriend that wants it; because not using the condom is seen as an expression of love and that he is special.

Some of the service providers commented that some cases of condom “accidents” were probably excuses, not wanting to admit having unprotected sex with a regular partner. As one of the service providers pointed out: *Who wants to admit their own mistakes, like I have not used a condom and now I might be pregnant. That's difficult.* Not admitting to one's own mistakes can be difficult, but it can equally be hard to acknowledge demands from partners and power relationships in one's private lives. As this service provider reflected:

[...] It is easier to say; “the condom broke”, than; “I have been visiting my husband and we had sex without the condom, because this is what he wants. I did not use any other contraception and now I am pregnant”. However when we calculate the first day of the last

menstruation to see how many weeks they are in their pregnancies, this date often coincides with the last visit to their regular partner, or when partners were visiting them in Norway [...]

According to the service providers many girls do not use condoms with their regular partners. Other studies have also confirmed the challenges of condom use in intimate relationship between sex workers and regular partners (Day 2007, Chacham et al. 2007, Sanders 2005, Mak 2004, Day & Weber 1999, Warr & Pyett 1999, Waddell 1996). Research has found that sex workers often find it difficult to use condoms with regular partners, nevertheless the reasons are complex. First, there is the issue of power dynamics in the relationship, and that partners would interpret condom use to be a sign of distrust (Stadler & Delany 2006, Sanders 2005, Vanwesenbeeck 2001, Warr & Pyett 1999). This is consistent with the perceptions held by the service providers in this study. Furthermore, this was reflected in how service providers told that a common practice among the women was to take copies of their negative test results to bring and show their partner as “proof” of being “clean”. In addition, studies have pointed out how condoms have a specific meaning regarding the separation between commercial sex and sex with intimate partners (Day 2007, Sanders 2005, Warr & Pyett 1999, Waddell 1996). It has been found that condom usage has frequently been associated with sexual transactions with clients; using condoms with intimate partners would therefore make it more difficult to distinguish between the two types of sexual relations. When condom usage is viewed as a symbol for commercial sex, it acts as a barrier for creating intimate relations. Non-use with regular partners is thus more likely to occur, as the absence of condoms becomes a symbol for trust, love and intimacy (Sanders 2005, Mak 2004, Warr & Pyett 1999, Waddell 1996). This puts many sex workers in a vulnerable situation regarding contracting HIV, other STIs and unwanted pregnancies, especially if their regular partners are not monogamous or they change intimate partners often (Warr & Pyett 1999, Waddell 1996, Day et al. 1993). In this study the data on condom use among partners are mostly based on perceptions and experiences from service providers. It is therefore difficult to say how the sex workers themselves viewed the relationship between sex work, condoms and regular partners. However, the finding that sex workers are more reluctant to use condoms with regular partners should be seen as valid, as service providers’ impression are based on numerous conversations and consultations with different sex workers over time. In addition, literature in the field also supports this finding. The

aspect of women's need or desire to have sex without condoms with intimate partners was not reflected upon by the service providers. This was rather seen as a demand from partners, overlooking the equal desire for sex workers to feel skin or closeness from their partners. These needs and matters should be further investigated as this will have implications for how health workers should address the issues of condom use, dual protection and unwanted pregnancies among their users. It is important to gain more thorough knowledge about the social and emotional realities, as well as challenges, that sex workers face when combining commercial sex with emotional relationships. In instances of non-use of condoms and with no additional contraception, there is always the chance of getting pregnant. Since one of the health issues at the Pro Centre's clinic is unwanted pregnancies, the promotion and awareness of hormonal contraception is one of their major working areas.

4.4.2 Hormonal contraception

According to the health personnel at the Pro Centre more Eastern European sex workers used hormonal contraception, and this was one of the main reasons for them coming to the health clinic. All except one of the Eastern European sex workers in this study used one form of hormonal contraception, the most commonly being the oral contraceptive pill. The informants had different reasons for using hormonal contraception. One informant used it to regulate her menstruation cycle while another used it to control skin problems. One informant related her present use of hormonal contraception to her previous experience with abortion, and expressed clearly that she did not wish for this to happen again. The Eastern European sex worker who did not use hormonal contraception had previously used the oral contraceptive pill. However, she quit when she experienced unwanted weight gain after a few months. Due to this experience she was very determined that she would not use this contraceptive ever again.

None of the Nigerian sex workers interviewed currently used hormonal contraception, although three of them had used it before. The main reason for not using this type of contraception was that they did not have sex without condom and therefore did not see any need for additional contraception. Those that had previously used hormonal contraception said that this was when they were in a relationship with a regular partner. Among yhe

Nigerian informants there was a tendency that the usage of hormonal contraception was seen as confined to being in a relationship with a regular partner.

The health personnel at the Pro Centre emphasized that there was a distinction between the perception of using hormonal contraception among Nigerian and Eastern European women. According to the health personnel, the Nigerian women had a different conception of hormonal contraception and this was strongly tied to cultural beliefs about fertility. These beliefs were centered on a need for a regular menstruation and the importance of being able to have children in the future. Health workers pointed out the difficulties in explaining to the women that even though their menstruation cycle could be altered when using this type of contraception it would not have any consequences for their future fertility. The menstruation cycle in itself was additionally central in how the women perceived hormonal contraception. Health personnel told how they perceived the women's need for having a regular and strong menstruation and this was explained with cultural references. This is how one health worker explained the significance of menstruation for many of the Nigerian women:

[...] According to their [Nigerian women] perception, the usage of hormonal contraception is not good, because they need to get rid of their blood every month. The blood has to go out, and it has to be the same amount of blood, and it is the bad blood that needs to pass out. So, it is like there is a cultural crash to try and give, because there are different types of hormonal contraception, and to try and give someone a type where they will lose their menstruation that is just wrong in a way, because that will result in a lot of commotion[...]

The health workers' awareness of the significance of menstruation for Nigerian women coincides with other research showing how menstruation is seen as a way of "getting rid of the bad blood". As Glasier et al. (2003) point out, interference with this bodily function can be viewed as disturbing. With respect to the importance of menstruation it should be noted that this is not confined to Nigerian women, as it has been found that women in European countries also perceive menstruation as a physiological symbol of reproductive functionality. For instance, the monthly withdrawal bleed was purposively introduced in the development of the combined oral contraceptive pill as an assurance to the contraceptive users of regular reproductive functions (Glasier et al. 2003). In addition, viewing menstruation as being a

way of getting rid of toxins and that it is natural and tied to femininity was also found in a study among Spanish women (Sánchez-Borrego & García-Calvo 2008).

Several of the health workers told that many of the Nigerian women that had started to use hormonal contraception had quit, due to loss of menstruation or the fear of becoming barren. Research conducted in Nigeria by Otoide et al. (2001) support the perceptions held by the service providers in this study. In their research on contraception among adolescents in Nigeria, Otoide et al. (2001) found that a common belief was that hormonal contraception would interfere with future fertility, making it more difficult to conceive, or even worse become barren. This belief was evident even among the more educated participants. In another study on infertility in Nigeria, by Okonofua et al. (1997), hormonal contraception was stated as a direct cause of infertility among the research participants. This is an important finding, since being infertile in a Nigerian context has severe social consequences. This is especially true for women, since men are seldom seen as the reason for infertility. In addition, infertile women are frequently avoided by other members of society, due to suspicion of witchcraft, and they are frequently banished from the husband's house (Okonofua et al. 1997). The belief about hormonal contraception and infertility was confirmed in one interview with a young Nigerian sex worker. The following quote shows how she explained why she had quit using the pill, and how one of the health workers at the Pro Centre had confronted this belief about hormonal contraception:

[...]because somebody explained to me that when too much of pill, a woman take too much of pill, and when she wants to get pregnant, then you have to wait for many months or years before she can, take in the baby [get pregnant], so I was like afraid of, I'm really want to get married, what if I get married and I have problem for pregnancy or something like that, so that's why I stopped using pills, but the nurse here make me to understand that; no! it doesn't cause anything, whenever I want to get pregnant; I stop using, then I get pregnant, so she advised me on using the, the plaster instead of the pill. The plaster is good, because the pill I can easily forget, but the plaster, I can't forget the plaster, because I just have to put it on my body, but the pill I can easily miss on the time, I can easily miss on the day, so it's better with the plaster, so maybe from now I'll be using the plaster.

In this case, it is interesting to note how this woman states that she is more likely to use hormonal contraception in the future. Nevertheless, she does not seem totally convinced, something which indicates how essential fertility is for her and that the cost of losing it would be unbearable. This underlines the challenges health workers are met with when trying to promote hormonal contraception. In this context beliefs are very difficult to change, or challenge, since the perceived side-effects are so devastating.

Correspondingly, there was a clear tendency that the health workers thought that it was easier giving advice on hormonal contraception to Eastern European women, because they did not have the same belief that it would affect their future fertility negatively. One of the health workers explained the difference like this:

[...]The issue of fertility and being able to have children is really embedded in African women in a very different way than for example with Eastern European women. They have a more pragmatic relationship towards it: "I make a living from selling sex, I have sex, I definitely do not want to become pregnant. How can I prevent this?", and then it is a lot easier to approach them with the concept of hormonal contraception [...]

In each group of informants there were examples of feared or experienced side effects of using hormonal contraception, in these cases the oral contraceptive pill, that lead to disruption of use and prevention of future use. Nevertheless, the characteristics of these examples differed. The Eastern European woman mentioned the experience of a sudden weight gain as the cause, while the Nigerian informant said the fear of being barren directed her to quit. The difference in these two examples is likely to be anchored in attitudes and beliefs about hormonal contraceptives emanating from the informants' cultural and social perceptions, experiences and backgrounds. Still, the Nigerian women's beliefs about hormonal contraception were more unfamiliar for the health personnel and they found it more difficult to approach and comprehend. Whereas the fear of gaining weight as a consequence was more understood and accepted, because it is a more common cited side-effect well anchored within the biomedical perspective. Still, the question of weight gain when using the oral contraceptive pill is contested (Gupta 2000, Risser et al. 1999). However, infertility is not seen as a possible side effect in the medical community, hence this belief collides with established biomedical beliefs and knowledge. This is not an argument

for the probability of hormonal contraception causing infertility; it is rather to show how different and unfamiliar such a belief might come across in a Norwegian health care setting.

The cultural and social significance of fertility in the Nigerian society and the way hormonal contraception is believed to interfere with this, puts the challenges faced by Norwegian health workers into a broader perspective. This underlines the importance of understanding the wider cultural and social context of these women. The findings in this study show that the service providers have an awareness of the cultural and social meaning of fertility in Nigeria, however it is seen as unfamiliar and difficult to address with regards to issues like hormonal contraception. In addition to more knowledge, there should be an increased dialogue with cultural mediators, as they can guide health workers on how to approach these issues in a culturally sensitive way. Again listening to the individual patient is vital, as not all Nigerian women have the same sets of beliefs. Some of the Nigerian women have been in Europe for a long time, something which is likely to influence their health beliefs. In addition, these women come from different parts of Nigeria, have different educational levels and so on. Still, it must be recognized that issues of fertility are deeply rooted in most societies and beliefs centering on such an issue are likely to be well-established. Day (2007) describes how she found infertility and fertility to be important in sex workers life as they represented a preservation of the inner self, symbolizing a future and family life. It also signified a visible demarcation between sex for procreation and commercial sex. Being infertile would mean that the inner self is broken and future prospects of fertility would be impaired.

In other words, the beliefs and worries expressed by Nigerian women in this study can be relevant for women across various social and cultural settings. Nevertheless, the hegemonic state of biomedical beliefs and the acceptance of medicines regulating different aspects of our bodies might make these beliefs appear distant and unfamiliar in a Norwegian health care setting. In this study it was found that the Eastern European sex workers represented attitudes toward hormonal contraception that were in line with this perspective, and was easier for the health workers to approach. It is acknowledged that hormonal contraceptives cannot make you infertile, this is not the issue raised here. Rather the challenge here lies in how health workers can promote contraception that keep Nigerian sex workers from having unwanted pregnancies, without them being scared or worried that this method will leave them sterile.

As mentioned previously, condom use is seen as complicated regarding intimate relations. In cases of non-use of condoms with partners, or possibly clients, condom breakage or slippage and where no additional contraception is used, the issue of unwanted pregnancies becomes central. Unwanted pregnancy and abortion was mentioned by most service providers as one of the key reasons for patients seeking health care at the Pro Centre; this is also reflected through the yearly statistics and report (Pro Sentret 2009).

4.4.3 Abortion

According to the Pro Centre's yearly report for 2008 there had been an increase in pregnancies compared to the previous year. Among the 69 pregnancies detected at the centre, 12 wished to keep the baby. The centre registered 35 abortions performed at health facilities in Norway and 3 self-induced abortions¹³, 3 miscarriages and 2 cases where the women had gone home to their countries. In addition, there were 12 cases where the outcome was unknown (Pro Sentret 2009).

Among the women interviewed for this study, three Eastern European sex workers and one Nigerian sex worker had had an abortion. One of the Eastern European informants had done it here in Norway, while the three others had done it in their home or staying countries. It was clear that the question of abortion was a complex question for most of the informants. For some of the informants abortion was seen as an okay alternative depending on the circumstances, while for others it was seen as directly wrong no matter what.

One of the informants spoke about her own experience with having an abortion and that it was a difficult choice for her. She expressed great grief about having to make that decision, but she explained it in terms of her circumstances at that time: *[...] if I was in a good situation, I don't was working in the street, then I don't do this abortion, never, no, but it's very difficult; one baby and work in street.* The informant already had one child in her home country and had partly started selling sex to provide for this child and the rest of her family. As she describes, the thought of having the economic responsibility of another child at that

¹³ Self-induced abortion is here defined as women provoking an abortion, by for example taking different medication, outside an approved health service.

point in her life was unbearable. Later in the interview when discussing reasons for using hormonal contraception she answered: *Because I don't want to, to do something wrong again. It's not nice to, to kill.*

Payment for abortion was an issue that service providers discussed. Most held the opinion that it should be free, due to the fact that abortions were usually paid for by selling more sex. This was seen as complex and unfair by many of the service providers, as one of them explained:

[...]I think the question about payment for abortion is very, very complicated, because I think it is hard to tell a pregnant woman that wants an abortion and is in a difficult situation that; " I am sorry, now you have to go out in the streets and make seven and a half thousand kroner so you can go to the hospital and have an abortion" [...]

Still, one of the sex workers said that she did not have a reason to criticize the fact that she had to pay for an abortion in Norway, because in her home country she would also have to pay. According to her, payment could have a preventive effect on future behavior: *[...] because you have to pay, then you have to think also next time, so you don't have to go and throw your money away to the doctor.*

In 2007, the Pro Centre was given extra funding by the Norwegian Directorate of Health¹⁴ set aside for abortions to those that were not entitled to free abortions in Norway. This funding was however not renewed and ran out in the beginning of the year 2008 (Pro Sentret 2009). Being able to provide free abortion was viewed as positive by the service providers, since many female migrant sex workers otherwise would have difficulties paying for it. Furthermore, the question of payment was seen in relation to the issue of self-induced abortion. The service providers said that even though it was not so frequent, they had some cases. So instead of going to the hospital and paying for an abortion, it was reported that some women would take different medications to provoke an abortion. In the aftermath they would come to the Pro Centre's clinic with infections, pain or bleedings. Even though the

¹⁴ Sosial og helsedirektoratet

service providers warned women about this practice, some choose this solution because the cost of having an abortion through health services was not affordable. The cost of abortions has been recognized as a barrier to accessing safe services. For instance, in the US many women do not have insurances that cover such a service, meaning that a large proportion of patients have to pay for an abortion themselves. This is especially hard for women with a low socio-economic status, as they often go to great extents to find the appropriate funding. There has been little evidence of high cost leading to self-induced abortions; however other consequences have been delays of abortions as women need time to allocate funding. Such delays can have negative health consequences as the risk of complications of an induced abortion increases with time. Another consequence has been that some women have to go through with their pregnancy even though it was unwanted (Fried 2000). It is difficult to find literature that has explored the consequences of paying for abortions in a Norwegian context, as citizens would get it covered by the National Insurance Scheme. However, arguments have been laid out for the provision of economic support for migrant sex workers in order to prevent illegal or self-induced abortions (Mård et al. 1999). In this study, the service providers pointed to some cases of self-induced abortion as a result of the cost, as well as the challenges these women have in allocating the proper funding.

With regard to the cost of abortions in Norway, the service providers had an impression that some of the Eastern European women were more likely to go home and do it there. However, they also emphasized that many women in this group also chose to have it done in Norway due to travel expenses and possibly shame and suspicion from family members about the reason for their pregnancy. Even though some of the sex workers commented on the price for an abortion in Norway, most said they would prefer doing it here.

Concerning the question of unwanted pregnancies and who the father was, most service providers had the perception that it frequently was a regular boyfriend and not clients. This was based on their notion of regular partners' wish for sex without condom and infrequent usage of hormonal or additional contraception. This was confirmed in one of the interviews with one of the female sex workers. This is how she reflected around sex work and pregnancies: *Maybe they have boyfriend, they have boyfriend, I don't believe that it's because this work in the streets, that you got in this situation [pregnancy] from that.*

This is not to say that unwanted pregnancies with customers do not occur, as sex workers might experience condom ruptures with clients. However, unwanted pregnancies could also be a result of non-usage of contraception with regular partners due to the challenges raised by condom usage in intimate relations. Thus pregnancy might be the result of such relations when no other types of contraception are used. This has been found elsewhere, as a study done among street-based sex workers in Rome found a tendency between low usage of hormonal contraception, low usage of condoms with regular partners and a high level of voluntary abortion (Verster 2001).

In 2008 there were 69 women who tested positive for pregnancy at the Pro Centre health clinic, 59 of these were Nigerian women. It should however be noted that the majority of the clinic's patients are of Nigerian origin (Pro Sentret 2009). As previously discussed the health personnel faced many challenges when promoting hormonal contraception to Nigerian patients, still the numbers of pregnancies and termination of pregnancies reflect that there are challenges related to unwanted pregnancies and contraception among this group. Due to the findings of commitment towards condom usage with clients in this study and in other literature (Day 2007, Sanders 2005, Jeal & Salisbury 2004, Vanwesenbeeck 2001, Warr & Pyett 1999, Waddell 1996), it is likely that this issue touch upon challenges of balancing sex work with intimate relations in a private life. For example, Oitode et al (2001) found that many Nigerian adolescents in their study did not consider condoms as a way of avoiding pregnancy; it was rather seen as a method for preventing infections. In addition the probability of possible complications of an abortion affecting fertility was perceived as low, only occurring on a rare basis. In other words condom use, hormonal contraception and abortions are interlinked in many different ways. The findings from this study are consistent with other research in that non-condom usage with regular partners and/or the non-use of additional contraception poses health challenges such as risk of infections and unwanted pregnancies. The service providers in this project expressed challenges in promoting hormonal contraception to Nigerian sex workers. Literature seems to support the notion that in a Nigerian context hormonal contraception is frequently believed to impair future fertility, something which often leads to low usage of such contraception. Interventions and service providers working with these questions need to address the social and cultural worlds of these women, as this forms perceptions of health beliefs and influence behaviour choices and patterns.

4.5 Overall discussion of the chapter.

Throughout this chapter it has been discussed how various health beliefs shape how health and illness are understood and explained differently across cultures and social settings. When different sets of belief systems meet, conflict situations can arise or individuals might readdress their previous perceptions and explanations in light of dynamic interactions and knowledge exchange with others. First, this issue was examined by looking at the meeting between migrant sex workers and health workers at the Pro Centre's clinic, and how different conceptions of health, body and sickness was presented, explained and addressed. The health personnel especially found the health beliefs of Nigerian sex workers to be more foreign and challenging to approach. However, it was found that the health workers were aware of these differences, and very much concerned with facilitating communication and treatment to these women. In this respect, an argument was also made for how cultural mediators can play an important role in mediating different culturally and socially formed health beliefs.

The issue of mental health needs was discussed. In this respect, service providers perceived different complaints, such as body pain, to be an expression of psychological distress. However, this was seen as challenging to address, as the sex workers seemed to have a different perception of these conditions. This illustrates how mental health can be understood and interpreted differently across cultures and social settings. It was therefore argued that a better understanding is needed in terms of how these sex workers interpret and explain such complaints, before any interventions are put in place.

Regarding the issue of risk, in terms of disease transmission, it was found that this was mostly associated with clients. It was also seen how sex workers had different strategies for avoiding risk, such as blood tests and no-touching policies regarding customers. The sex workers strategies for protection were found to have high priority, in some cases coming into conflict with health prevention messages. Finally, attention was given to how condom use, hormonal contraception and abortions are interlinked. Consistent condom usage with clients was found. However, due to the association between condoms and clients, non-usage with regular partners was seen to be a challenge for the women's health. In addition, health beliefs about hormonal contraception seemed to lead to a low usage, this was especially evident among the Nigerian sex workers. It was found that unwanted pregnancies and abortions were

seen to be a result of non-usage of contraception with partners, rather than being caused by condom ruptures or unprotected sex with customers.

In this chapter, it was pointed out that interventions and service providers need to address the social and cultural worlds of migrant sex workers, as this forms perceptions of health beliefs and influence behaviour choices and patterns. Moreover, power relations, emotional relationships and social reputations were also found to influence health behaviour. Social factors that influence behaviour will be addressed more thoroughly in the next chapter.

5. Health behaviour and service utilization

Exploring health beliefs is an important element in understanding how people behave according to their health needs. However, individuals are not isolated actors, but are parts of wider social and cultural networks. Social relations also affect our behaviour, through norms, power relationships, motivations and discouragement. Regarding health, we often seek advice from our friends or families. In these way social relations affect or treatment seeking process, as we often consult others for recommendations for treatment possibilities or put weight to their experiences. In addition, individuals are surrounded by structures, which can be seen as ways of organising various social interactions. These can facilitate or limit individual behaviour. Structures, in the form of health care rights, can for example both facilitate and limit access to various treatment options.

This chapter deals with female migrant sex workers' health behaviour in terms of the usage or non-usage of different services. First, the question of telling health personnel about sex work experiences will be addressed, by discussing how stigma can act as a barrier to such disclosure. Furthermore, the issues of using different health services as a strategy for separating sex work from other parts of one's life is examined. Then, different reflections on services targeted at sex workers is considered, identifying how these can be influential for health behaviour and service utilization. This is followed by an exploration of perspectives on money and health, putting an emphasis on health care systems in origin countries and whether the subject of health care rights affects treatment opportunities. Ultimately, experiences from various health services will be examined to see how attitudes and expectations towards health personnel can affect choices of services.

5.1 The secret - Disclosure of sex work to health personnel

All of the Eastern European sex workers except one had a regular doctor they could visit in their home country or in other European staying countries. The one woman that did not have a general practitioner, said it was because they did not have this system in her country, but that she could go to a hospital for health care when needed. All but one of the Nigerian sex workers had some kind of staying papers in another European country and all, but one had a

regular doctor they could go to see there. The Nigerian sex worker that did not have staying papers in another European country only used the Pro Centre's doctor. All the informants, except one, that used health services outside Norway said they had not told other health personnel about their experience with sex work. A general trend was therefore that the general practitioners these women used outside Norway were unaware of their sex work. This finding is consistent with findings from other studies done on sex work and health (Romans et al. 2008, Kurtz et. al. 2005, Jeal & Salisbury 2004, Renland 2002, Mårdh et al. 1999).

The reluctance to disclose sex work to health personnel is a complex and multifaceted issue. At one level it relates to the fear of being treated differently by health personnel, due to the perceived views about sex work in society. Sex work is touching on moral values and it is often seen as something conflicting with moral standards and both sex workers and clients are therefore seen to display deviant social behavior (Vanwesenbeeck 2001). Being a part of something that is considered as socially unacceptable will have an impact on how women selling sex feel about themselves and how they think others perceive them. Informants therefore spoke about shame inside and a feeling of little respect. The aspects of shame and disrespect can be reflected in the terminology informants used when talking about sex work. This was referred to as dirty or bad and this work was always contrasted with other types of work which was termed as normal. Sex work was therefore often perceived as something temporarily done out of economical constraints. As illustrated by the following quotations:

[...]it's not a good job to do, I just have to go in some time, but for me it's not a good job, it's not my WORK, it's not the work I like to do, but I have to do it to live. But not forever, no.

Another woman explained her reason for selling sex like this:

[...] it's condition that make somebody to do it. If you are okay I don't think anybody would go and stand on the street. It's condition, like you have children in the school, they need money and you don't want to steal, you don't want to carry cocaine, so okay let me do this. It's condition.

When asked why they would not tell their doctor or other health personnel about selling sex it was obvious that they feared this would have a negative impact on the consultation. One informant said that if the doctor knew, she thought he would treat her differently:

Researcher: *have you ever told a nurse or a doctor in your country that you have worked in the streets?*

Respondent: *No, never. No.*

Researcher: *Is it something you feel you could tell them?*

Respondent: *It's not nice [the sex work], you know, in my country and in your country it's; everywhere it's dirty work and everybody. No, [nervous laugh] I don't want to.*

Researcher: *Do you think they would treat you differently these doctors if you told them you work in the streets?*

Respondent: *Of course! I think so yes.*

Researcher: *Have you heard some stories about this?*

Respondent: *No. I don't think anybody will go and say, you know, I need health care, I work in the street and as prostitute, no, I never, I never hear that.*

This informant had not experienced an actual situation where health personnel had discriminated her or heard about someone else with this experience. It was rather an expectation constructed around the moral realm of sex work in society. It is then not a reflection of the health personnel behaviour per se. It is rather an indication of the inner fear and shame that the sex worker brings into a meeting with a health worker that prevents her from bringing up health related aspects of selling sex into the consultation. Even though the sex workers interviewed in this study had not had any actual negative experiences related to disclosure of sex work to health personnel, this has been found in other studies (Chacham et al. 2007, Stadler & Delany 2006, Wojcicki & Malala 2001, Aral et al. 2003, Montgomery 1999). The difficulty about telling health personnel about sex work due to fear about stigmatization has also been found among sex workers on the indoor sex market in Norway. In her report, Renland (2002) found that these women thought it was hard to tell health personnel about sex work, and to avoid suspicion they would change doctors. By changing doctors they would avoid questions about why they wanted testing for STDs and gynecological exams more frequently than usually recommended. Since nearly all of the women in this study kept sex work as a secret for their doctor, it is difficult to predict how

their experiences would have been if they were in fact to be open about their sex work, and whether discrimination would have taken place. However, the expectation of being discriminated against by health personnel is a reflection of how the women interpret societal attitudes towards those selling sex, and the social stigma they bear with them also in a health care setting. This stigma is created and reinforced by wider moral discussions and norms, thus leading to an expectation of stigmatization and discrimination from others. The findings in this study may however suggest that the self-stigma, transferring into fear and secrecy, might be more limiting for these women's health behaviour than actual incidents or experiences of stigmatization and discrimination.

5.1.1 Two lives – two doctors

Another reason for not telling about their sex work to health personnel was due to the fact that many of the women separated this from the life lead in their home country or staying country. Many spoke about sex work as something they only did in Oslo and that it was something secret or hidden from their social network at home or in their staying country. For many of the informants it was important to underline that sex work was not something they wanted to do the rest of their lives, it was rather a condition due to family obligations of economic nature or economic hardship. Many of the women spoke about their previous work, their family lives and relations outside Norway. It was important for them to make a distinction between sex work and their life at home or in their staying country. Sex work was seen as just work, while their true lives and identities were elsewhere. In the interviews it was important for many to emphasize and describe their “proper lives where they had normal jobs and families”. Logically the side of their lives which involved selling sex was not something they wanted to tell or share with people at home or in a staying country, not even health personnel. As one of the women explained:

[...] that is why when you asked me that with my doctor in Italy, [We had previously talked about if she could tell her doctor in Italy about selling sex in Norway] I cannot tell him, this is my secret, I can't. In Italy much of them they don't even know what I am doing [...]

Disclosure about sex work to health personnel in their home or staying country then translate into a wider frame, not only relating to fear or prejudices from health personnel. It is also a way of enforcing the duality of one's life, by protecting the life that is lived outside the realm of sex work. The external aspect of this protection strategy can be seen as preventing someone at home or in your staying country finding out about the sex work. For example one informant said that her regular doctor was a friend of the family and she therefore could not tell him, in case he would come to their home and tell her family. Fear of someone finding out is thereby linked to the aspects of stigma and moral views about sex work in society. Keeping sex work a secret from family member or other social relations has been pointed out in several studies on sex work (Chacham et al. 2007, Skilbrei 2007, Bucardo et al. 2004, Sanders 2004, Renland 2002, Alexander 1998, Høigård & Finstad 1992). The fear of someone finding out is something which stays with the women throughout their lives, and can result in psychological stress (Sanders 2004). This fear is built on cognitive constructs about how a potential disclosure would affect one's relationship with family and also wider social networks. The negative connotations of sex work in most societies will therefore reinforce this fear, making it crucial that disclosure does not occur, as illustrated by this quote:

[...] this is my private. I not talk about me there, old friends other. I have son go to school, other mamas, son go together school, I never speak about my business here over there [...]

At the same time the internal reason for not wanting to tell anyone outside Norway about selling sex can be seen in relationship to the separation of one's lives into one sphere with sex work and another one at home or in a staying country. The geographical distance that these women have between their two lives also underlines and facilitates these two realms of their lives. The division made between these two lives can be seen as a way of protecting oneself. It is a way of distancing oneself from sex work and preventing it from becoming a part of one's identity. By building and maintaining this duality in their lives, it is easier to see the sex work as "just" work where one plays a role in a specific setting. One of the women put it like this: *[...] I just do this for work you know, for me it's not that I am thinking with heart you know, this is just work.* As this quote shows the sex work setting is separated from

one's personal lives, feelings, values or identities. The distance this duality creates and rebuilds is functioning as a strategy to shut out the shame and disrespect related to sex work when one is at home or living their "normal" life. Day (2007) discuss a similar finding in her book about sex workers in UK. She points out how different rules were drawn up by female sex workers as protection strategies in order to separate sex work, from their private lives. This is a much discussed issue in the literature on sex work (Day 2007, Skilbrei 2007, Sanders 2004, Renland 2002, Warr & Pyett 1999, Høigård & Finstad 1992). However as Shaver (1994) has argued such strategies are not unique to sex workers, as other professions also has strategies and methods for creating distance. Sometimes emotional distancing is required as a way of emotional protection while working, in other cases it is integral to professional ethics. The last part is especially true for people working in care profession, like nurses, doctors and social workers. Still, it remains an important strategy for sex workers when it comes to protecting their private lives. For example, Høigård and Finstad (1992) describe how Norwegian sex workers have different strategies for protecting their private live. One method was to create a new identify, by specific clothes, wigs and make-ups, and be strict about not revealing anything personal. This was usually combined with other strategies, such as drawing bodily borders where certain activities and areas were off limit¹⁵. In this way the sex worker distances herself from the client, but is also creates distance between her and sex work. Framing sex work into an explicit role, with a specific uniform, facilitates the boundaries set between this role and one's private life and self (Høigård & Finstad 1992). Having a doctor reserved for this role can then be seen as an important part of this protection strategy.

Having two doctors, one confined to the "normal life" and one for the life as a sex worker, is a physical structure underlining the separation of these two lives. Disclosing sex work to a doctor or health personnel at home will lead to a merging of these two cognitive constructs, thus bringing the shame and stigma of sex work into the sphere of the "normal" live. The consequences of this can be difficulties in relation to their families and friends in their home and/or staying country, translating into shame for both the family and oneself. At the same time the internal consequences would be that the protection made by this separation of

¹⁵ The women interviewed for this study, mentioned similar protection strategies when talking about risk of disease transmission.

oneself is ruined and that sex work would become part of one's identity in both spheres of life. However it should be questioned whether this separation of one's live and consequently distancing oneself from sex work, treating it as *just* work, is a possible mechanism in the long term. Høigård & Finstad (1992) found that the mechanism of keeping sex work separated from one's private life became complicated in the long run and that the boundaries between the two realms got more difficult to maintain with time.

In this study it was clear that social stigma or self-stigma of sex work prevented many of these women from telling their doctors or other health personnel about this side of their lives. The reluctance to tell health personnel about their sex work experience is complex and has many layers. It is tied to the stigma in terms of negative expectations if health personnel were to find out, but it also relates to an internal protection strategy of separating one's live into two parts: a private part and sex work. Using two doctors can then be seen as a physical tool for separating these two realms of one's life, where the threshold for bringing sex work into an arena of one's private life, like a general practitioner, is seen to be high. As sex work involves special health needs and a high morbidity (Jeal & Salisbury 2004), a negative outfall is likely to be that these health needs are not addressed or met. In this way the social moral and values regarding sex work, as well as these women's own protection strategy can act as barriers for these women's health behaviour, even when risk or disease are recognized by the women themselves. In the absence of other services the affect on their health can be grave. However, in this study it was found that the women used an alternative health service targeted at sex workers for health purposes relating to sex work. How this service was viewed and it's perceived significance will be addressed in the following section.

5.2 Services targeted at sex workers in realtion to health behaviour

5.2.1 Understanding and acceptance

The difficulties in disclosing sex work to health personnel also affected how services that were targeted at women who sell sex were viewed. At these services disclosure is made at the doorstep, since these services are confined to women that sell sex or have experience with sex work. A lot of informants underlined the importance of this implicit disclosure or

openness when talking about positive features of the services. This point can be illustrated by what one of the interviewees answered when she was asked what she thought was the reason why women used the health clinic at the Pro Centre:

[...] because here they [sex workers] don't have shy to tell what they are doing, because this centre is only for women and they don't have shy in here I think. If I go in one hospital or something like this I have shy to tell I am in prostitution you know [...]

Additionally, another woman spoke about a feeling of relief that the doctor knew she sold sex and that it made the consultation much easier. In this setting she did not have to lie to the doctor about the number of partners she had, instead she could be honest. She expressed that this openness made her feel much freer. This same woman also said that if she later on got a normal job in Norway she would change her doctor and not use the health services provided at the Pro Centre. The reason she would not go there if she had a different job, was that she thought it would be better to be finished with everything related to sex work and thus change to another doctor. This underlines the duality discussed in the previous section of the paper about why many sex workers use two doctors; one for the health issues and needs related to sex work and another for health needs confined to their “normal lives”.

When speaking about what motivated the women for using the services quite a few spoke about the issue of confidentiality. Several highlighted that being able to speak to someone in secrecy was important, because it made them feel safe. As one of the Eastern European women explained:

[...]I can go to speak in secret, and this is very safe and nobody knows and this I think is very good, because, you know, when you talk with someone and he say to you it's safe, you feel, you don't have scare, yes, and this I like, it is good [...]

This was viewed as positive and was also a reason why the women kept coming back to the services. The promise of confidentiality applies for all health personnel and social workers¹⁶, however as discussed previously, outside the services most women did not want to tell about their experience with selling sex. The staff at the services is therefore in a unique position, due to the fact that they already know. The knowledge of the women's situation was frequently seen as an expression of understanding; the service providers knew, therefore they understood. This understanding implied acceptance and respect. This can be illustrated by how the women described the interaction with service providers in terms of statements like; *they know what we are doing, about our job, and they are very, very kind to us.*

The concept of understanding is likely to make it easier for sex workers to trust and confide in the service providers. In other words what embodies the roles as health personnel or social workers are perceived differently within these services, than outside. Hence they are perceived as more trustworthy and easier to confide in, than their counterparts at other services. This can be summed up in one woman's account of why she came to the Pro Centre:

In a way you know we are girls, we work in the streets and maybe people are nice to us, but not many of them, mostly people are really bad, so this place they know what we work with, they give free health care, food, you know, we can talk here, that's important for me. That I can come here, they know and they are nice to me, they don't look at me like I'm a bitch you know [laughing a little], or a bad girl so, I don't know, if I come to another place maybe they will not be nice if they know what I work with, but I don't know.

Research has shown that due to the vulnerability of many sex workers and the stigma they are met with in many parts of society, it is vital to design and offer health services that have an atmosphere encouraging openness and honesty, free from moral prejudices (Stadler & Delany 2006, Mårdh et al. 1999, Carr et al. 1996). The findings in this study show how services targeted at sex workers circumvent the difficulties of disclosure and create an

¹⁶ By Norwegian law all health personnel and social workers are bound by the promise of confidentiality towards patients or clients. However the two professions are bound by different laws. The law on medical confidentiality can be found here: <http://www.lovdata.no/all/tl-19990702-064-005.html#21> The law on confidentiality for social workers can be found here: <http://www.lovdata.no/all/hl-19911213-081.html#8-8>

environment of trust and acceptance, hence acting as a motivator for these women's health behaviour.

5.2.2 *It's like a home*

When speaking about the services, many of the sex workers talked about the package of services offered. This was usually done when describing why they liked to use these services and it was clear that a combination of different services ranging from health care, food, internet, a place to relax and meet others were viewed as positive. This was something many informants emphasized and it was moreover a reason for maintaining contact with the services. Providing a variety of services was significant, and this was reflected in how these were interpreted into a wider meaning. Several informants mentioned that they felt at home at the services, and that the people working there cared for them. One Nigerian woman expressed the meaning of the services like this:

[...] we see fruit, food also, they make food; breakfast or dinner, so they make food for us to eat, there's fruit there. After we see the doctor, we still can stay, drink a coffee, and take a tea and the water. In the hospital it's not like that, just go and see the doctor and they take care of you, but here you can also eat, it's like you are in your home also, while they are taking care of you, that's why I believe here is good, they do help, not only the black girls, but almost all the girls that do the prostitution and they take care of them and they encourage them, don't be afraid, come close to the doctor and share your problem, so that they can take care of you [...]

The importance of the combination of different services was usually perceived in relation to the socio economic situation of sex workers. Many informants talked about economic difficulties in terms of finding a place to live or eating proper food, and services targeting these needs were therefore seen as crucial. How the services are given a deeper meaning can be illustrated by this quote:

[...] they wash clothes and dry them, you know, and take hygienically needs and some food and some help from the doctor. It's home for us. It's home, I don't use laundry and clothes in the machine, I'm in a good situation, but some people no have house, for them house is Pro Centre.

The notion of looking at the services like a home, or a place of safety was mentioned by several of the women:

[...] you know, when me, I go to Pro Centre, I don't go too much time, just if I have some problem, not every day, but when I go there I feel good, I find these nice people, I don't know, somehow I'm home.

The usage of the different services was also encouraged by the staff, for example at the Pro Centre when patients were waiting for the nurse or doctor, staff frequently offered the women to go into the kitchen area to have food. When it was time for their consultation, the staff would go and get them. Likewise there is collaboration between both Nadheim and the Pro Centre, and they would refer to each other's services. Staff at Nadheim would often tell about the health services at the Pro Centre, and courses or events at Nadheim would be advertised at the Pro Center.

Literature about health and social needs of sex workers, especially street-based sex workers, have often highlighted the benefits and need to offer integrated services combining basic and social needs with health services (Jeal & Salisbury 2004, Cooper et al. 2001, Carr et al. 1996). For the more vulnerable groups of sex workers, the basic needs like food, drinks and laundry services might be just as important as health care services (Kurtz et al. 2004). Having combined services at a place nearby the working sites of sex workers, with adjusted opening hours is facilitating this group's access to care and positively influences their health behaviour (Jean & Salisbury 2004, Carr et al. 1996). It has been shown that out-patient clinics or outreach activities might be better alternatives for certain groups of sex workers, especially those working from apartments or at brothels (Chacham et al. 2007, Stedler & Delany 2006, Ibbitson 2002). This is based on the argument that there is a distinction between sex workers working on the indoor market and the street, whereby the aforementioned group have difficulties in identifying themselves with services more frequently used by street based sex workers (Renland 2002, Skilbrei 2001). Tveit & Skilbrei (2008a) found that the women on the Norwegian indoor sex market had less frequent contact with services, and the services providers also identify this group as more difficult to reach than those operating on the streets. Since the women interviewed in this study were street-

based sex workers, with the exception of one, it is difficult to discuss how the women on the indoor sex market view the services and in what way this may influence their health behaviour. Nevertheless, in their project Tveit & Skilbrei (2008a) noted that some women working on indoor arenas had weak social relations and felt a need for social contact, thereby using the services as a way of meeting people. Still, the most cited reason by the women on the indoor market for having contact with the services were health related such as going to the doctor or picking up condoms, thus underlining the importance of having a health services targeted at women selling sex (Tveit & Skilbrei 2008a). In addition, it should be remembered that both Nadheim and the Pro Centre have outreach activities aimed at the indoor sex market (Skilbrei & Tveit 2008b). Nonetheless, the findings from this study strongly support the argument that a combined service including social, health and basic needs are important in improving sex worker's well-being. Due to the living conditions of many migrant sex workers, it is not always easy for them to get proper nutritional meals, or access to laundry services or computer services. Combining such services with health care services is more practical as one can cover several needs at one place. In addition the findings in this projects show how this also creates an atmosphere of social safety and security. Having a place of trust and safety is an important determinant for these women's health behaviour, since they have challenges being open about their sex work experiences with health personnel in public health care services.

5.2.3 Outreach – Condom as a symbol of double protection and care

Outreach can simply be said to be a method of accessing groups that are hard to reach, by creating contact and working with these in their environment (Cooper et al. 2001). Outreach has been an important component of health promotion programs, especially concerning HIV/AIDS prevention (Vanwesenbeeck 2001). In a public health perspective sex workers have been considered as a bridge population for STDs and HIV/AIDS, spreading these into the wider population through unprotected sex with clients. Therefore a lot of attention has been given to raise the awareness level of STDs and HIV/AIDS, as well as promoting safe sex behaviour, mainly through the distribution of free condoms (Cooper et al. 2001, Vanwesenbeeck 2001). Outreach can thus be said to be a strategy to protect the general population from disease transmission, as well as protecting the health of sex workers themselves and clients. However, in the era of the HIV/AIDS pandemic the aspect of

protecting sex workers' health in itself has often been a downplayed objective (Vanwesenbeeck 2001, Alexander 1998). Still, recently there has been an increased focus on sex workers' health as important in itself, and many have argued for a more holistic approach to this groups health needs (Cooper et al. 2001, Alexander 1998). Nonetheless, outreach remains an important element for many services and programs working with sex workers (Cooper et al. 2001, Mårdh et al. 1999). Both Nadheim and the Pro Centre have outreach as a part of their services, however how this is viewed by the sex workers themselves and service providers deserves attention. Observation in the field found little support for the traditional public health perspective, where the general population needs to be protected through safe-sexual behaviour of sex workers. Outreach seemed rather to have transformed into a service seen first and foremost as a way of ensuring sex workers well-being and health, where clients were seen as the ones representing health risks for sex workers.

Among the twelve sex workers that was interviewed two informants did not know about the outreach activities done by the Pro Centre or Nadheim. One of these two informants worked on the indoor market and her contact with the services had been through friends and she had not met anyone from the services when she was working. Almost all of those who knew about the services had met people from these organizations in the streets. For many of the women outreach was how they first came into contact with the organizations. The service providers underlined outreach work as an important part of their jobs. Outreach was seen as an entrance point, creating contact and trust with the women. It was also a way of informing sex workers about available services. In addition, they also saw it as an important method for disease prevention, since they were distributing condoms and other material. According to the service providers offering health services made it easier to create the first contact, as health was something most women were concerned with. Having an outreach team with a health worker, doubled this effect as nurses or doctors often signify trust and are easier for the migrant sex worker to relate to. For example the Pro Centre is frequently referred to as 'the hospital' among the foreign sex workers, underlining the significance of this service. As one service provider noted:

Usually the first meeting with the women is through outreach. In this situation we emphasize that we can offer health services, because everybody knows what a doctor or a nurse is. If you say that you can offer them a conversation with a social worker, some might

think what is that? But to say that you can arrange for a consultation with a doctor or a nurse that is something everybody can understand, and it is also very much appreciated and wanted. So health is definitely an important entrance point for creating contact with these women.

The outreach activities were described in positive terms by the sex workers. Several said they felt that this was an expression of care and that the service providers did it to keep the girls in the street safe. When talking about safety they usually referred to the distribution of condoms, and that by doing this the service providers showed that they cared about their health and wanted them to be protected from diseases and unwanted pregnancies. One of the sex workers described it in this way:

[...] I was very happy when I saw them [the outreach workers], you know it excited me. I never knew anything like this happened, it's nice, and it's somebody trying to be good to the people. It's nice. I was happy; they try to protect the ladies from having sex without the condom. They are telling us to use condoms all the time, so we don't have infections. It's nice, in this way you don't lack nothing.

However, protection and care was not only confined to condoms and other material. The informants also talked about how service providers would tell them to be careful with clients, put on more clothes and that they could always come to the services if they needed anything. Some informants also used the word encouragement to describe how meeting service providers in the street would make them feel. In this way the service providers' role is not only embodying the task of distributing material, but also has an emotional and caring aspect. In this way a service provider functions as someone who look out for the women in the street, giving physical protection in terms of condoms and emotional protection through words of encouragement and care. As one a young Nigerian sex worker articulated it:

[...] I appreciate them coming to the street and they always ask the girls: "are you okay? Be careful!" And I love the word they use, like encouraging the girls, "watch the men you go with, be careful, be nice and so the men can be also nice with you, and don't take the bad guys".

This coincided with how many service providers described outreach, as one of the service providers expressed:

I really think that outreach is very important. In this way we meet new people every day and we tell them about the services, and they usually drop by afterwards or contact us. In addition it is the aspect of being on their turf, where they work, and then they can see that we go around, we are there and we care. We hand out condoms, but it is not always the condom that is most important in itself, but sometimes it is just that someone came and gave them something, it is a way for us to show that we care about them and I think that is really important [...]

Nevertheless, one woman also spoke about the ambiguity of the meeting between her and the service providers when she was working in the street. She spoke about how these encounters could sometimes bring out other feelings like embarrassment and shame. Even though she underlined that she was happy about meeting the service providers in the street, this would also highlight her role as someone selling sex. She described it like this:

[...] I feel, I feel so weak, like, oh, somebody is encouraging me and that's like; you are doing a dirty job and the street is not so safe, so you have to try and get out of the job, so it's like this, I feel so weak, but I'm happy when they come. I feel so, sometimes I'm ashamed. Somebody's asking me, "be safe, put on more jacket so you don't get cold, be careful with the client" [...] I feel so, like I'm doing a dirty job, so I feel embarrassed sometimes, I feel embarrassed, but I still feel they're encouraging me; "be careful".

This quote shows how a meeting with service providers was seen to underline this woman's role as a sex worker in the streets. In this case the outreach activities seemed to activate an internal conflict regarding the respondent's attitudes towards selling sex, reflecting the emotional complexity of her situation. Nevertheless, it is also clear that despite this, the outreach workers were viewed as someone caring for her and other women in the streets, encouraging them and looking after them. This is likely to strengthen the trust and motivation for this woman to use the service offered by the service providers. It also shows how important it is for these women to feel they have someone that cares for them, actually

caring so much that they reach out to them in the streets. Health promotion activities become a symbol of care, protection and encouragement.

As shown in this section the outreach services, done by the organizations, were not interpreted in a typical public health perspective. Rather the sex workers viewed outreach as something that was established to protect them and their health, and that this activity saved them from getting infected by customers. For example, there was only one informant that mentioned how the distribution of condoms would also keep the men safe. This way of viewing outreach corresponded with how the service providers viewed it, and the aspect of protecting clients were rarely mentioned or emphasized by service providers as a consequence or aim of this activity. The findings from this study implies that outreach activities, such as condom distribution, was seen as a way of protecting sex workers ensuring they would be safe and protected at all times. Hence, the condom became a tangible material signifying both protection in a health perspective, and at the same time representing a more emotional meaning of care and protection.

This finding reflects how sex work has been viewed in a Norwegian context during the past years, where social work has been seen as the most suited approach to meet challenges of sex work. The social work targeted at sex workers has to a large extent been steered by ideological standpoints held by different actors and organizations within the field. The focus of these has been on harm-reduction, but not only in terms of providing social and health services. An equally important aim has been to respect sex workers, and enabling them to respect themselves (Skilbrei & Renland 2008). The main attention is therefore given to sex workers themselves, and as shown here public health initiatives are interpreted according to the values and perspectives held by the various actors.

In the case of outreach, a focus on protection and care for the sex workers was in this project found to have an encouraging effect for further contact with the services targeted at this group. It might also raise some internal conflicts within sex workers, such as shame or embarrassment. However, in this study it was found that the safety represented by outreach workers, or service providers, was still so important that difficult feelings did not result in a

wish from the sex workers for service providers to stop coming to the streets. An overall impression was that outreach was very important for the women in this study¹⁷, very much due to the common standpoints of how outreach was interpreted. Outreach has especially been seen as having a positive effect on the promotion of condom usage. Additionally it served as a motivator for utilizing health care services offered for this group, since many of the women came to the clinic after initially meeting service providers in the streets.

5.3 Perspectives on money and health care

The services provided at the Pro Centre's health clinic are free and available for all men and women that have, or have had, experience with selling sex¹⁸. Even though the main focus is on sexual and reproductive health, there is an increasing representation of other health needs as well. As noted in the yearly report for the Pro Centre many of their users utilize this health service more like a primary care service with the clinic's doctor being used as a general practitioner. This tendency was not only confined to migrant sex workers, but was also present among Norwegian sex workers (Pro Sentret 2009). However migrant sex workers usually do not have the imbursement of a third party, such as general social insurance, because they are not citizens in the country where they work (Mårdh et al. 1999). In these situations paying for services can represent a barrier for accessing health services (Wong et al. 2006, Mård et al. 1999). In this way a free health service like the Pro Centre's clinic might be the only place available for migrant sex workers. How the female sex workers viewed the aspect of using a free service will be discussed in the following section.

The role of free services was by many informants contrasted with experiences and perceptions of health care services in their home country. This was reflected through how some of the informants spoke about the way money controlled access to doctors and treatment in their home countries. The ability to pay was seen as the deciding factor to whether you would get medical treatment or not. Informants gave examples on how money

¹⁷ It should be remembered that the female sex workers represented in this study have all had contact with the existing services. It must therefore be acknowledged that sex workers that do not have contact, or regular contact, with such services can have different view points on outreach activities.

¹⁸ http://www.prosenteret.no/index.php?option=com_content&view=article&id=12&Itemid=26

would get you quick treatment and that the doctor would treat you more nicely. The examples and stories given were similar both among the Nigerian and the Eastern European women. One of the women from Nigeria spoke about how money was a barrier for seeking and getting medical care and that the lack of such resources was seen to result in dramatic outcomes:

[...] in my country, that's Nigeria, the problem is money. Yeah, the problem is money. So when you have money, they care about you. If you have money, you just come to the office and see the doctor, what you want, he's going to give you what you want, but if you don't have money they can't, they don't save life. They save money before life; it's the problem there, that's why many people they are dying [...]

The experiences and examples given in relation to the women's experience and perspectives on the cost of health care in their home countries should be seen in the context of challenges with health provision in Nigeria and the majority of Eastern European countries. It has been noted that informal payments to staff at health facilities are common in most Eastern European countries, especially for former Soviet Union countries (Ensor 2004). This has been due to the decline in government funding, which often meant lower allocation for health care. As a result patients had to bear more of the costs of health care, contributing towards the cost of food or medicines. However costs have not only been confined to material items, payments to health personnel have also been a widespread practice. These payments are given to ensure quality of care and to ensure that procedures or treatments are carried out. For example in Albania it has been found that all clinic staff receive payments, or bribes, with the highest being given to the physicians carrying out the procedure in question. Informal payments are additionally used to gain access to certain services and facilities or to save time (Ensor 2004, Lewis 2000). In Nigeria, the story is somewhat different as informal payments have not been portrayed as the main challenge. Nevertheless this country also has a story of macroeconomic changes and challenges, affecting health care provision. In the eighties all public medical services were free; however in 1984 the public sector experienced severe economic difficulties which eventually resulted in low government expenditure on health care. The manifestations of the crisis for the health sector were reflected in shortages of personnel, equipment and drugs. The government tried to address these difficulties by introducing user-fees. Still, the imposition of user-fees together with problems of shortages,

led to a general discouragement of the usage of public health facilities. Instead most patients turned to private medical services (Alubo 2001, Ogunbekun 1999). However, the private services are also recognized by their high fees for patients and the quality has been stated to be poor. As a consequence price is often a determinant regarding access to care, often leading patients to seek care when their conditions are already severe or acute (Alubo 2001).

The role of money, whether it is in the form of informal payments to health personnel or as a pre-requisite for gaining access at all, remains a significant factor for health behaviour. Even though the Eastern European tended to speak about corruption in direct link to health personnel, the Nigerian women viewed money as a barrier of accessing the health care system. Nevertheless, the result was similar, that both groups expressed distrust towards health services in their home countries. Using and being offered a free health care service in Norway must therefore be seen in relation to these contextual circumstances. This would in part help to explain the positive attitudes towards receiving services without charge, what they think would happen if the services suddenly stopped being free, and how health personnel at such a service was perceived.

When asked what they would do if the free service suddenly turned into a service they had to pay for most of the informants said that they thought they would still come. Still, it might seem that the frequency for using health services in a preventive way could be limited by the prospective of having to pay for it. One informant spoke about how going to test oneself once a month would be very expensive if she had to pay for it herself, and that she then thought she would limit the testing to just once every two months. Regarding the issue of paying for services a majority of the women emphasized that they would still come, but that they thought that payment would be very difficult for many other girls. At the same time they underlined the importance of having a free service, as this woman reflected;

[...] so it's very important for us and we, we believe they are trying if we are sick; "come again and go sleep and come again", they are trying, because if they had to go to the hospital everyday and pay for this charge, you know what it will be, it would really cost them money and why, they cannot even afford it, so they will just die in their room [...]

Reflections like these can be seen as an expression of own previous health experiences from home countries, or stories told by others. In this quote it is clear that not being able to pay for services is seen to have severe consequences, and that the issue of payment is difficult for many. It is also interesting to note that interviewees often made a division between themselves and the so called other girls, highlighting themselves as better off and being able to pay. This way of portraying oneself in comparison to other people in a similar situation or group can reflect that informants wish to highlight their self-efficacy and control over their own lives, health and actions. This is in line with Sander's argument being that health was one area where sex workers feel they have control (Sanders 2005). On the other hand it could also be the case that these women were better off, thus being able to pay for health care. Still, both the Eastern European and the Nigerian women very often stated that the most important reason for going to the Pro Centre's Clinic was that it was free, and this coincided with service providers' impression of the significance of offering free health care. This substantiates the notion that having a free health service for migrant sex workers plays an important role in relation to their health behavior.

When talking about receiving free health services the informants often talked about this in relation to how they saw the people offering or carrying out these services. They did not speak about the systems providing these services or the political frames around this issue. Rather they spoke about health personnel and how money would determine the quality and level of treatment given. Treatment is in this sense not only implying medical procedures, but also how health personnel would speak and interact with the patient. When describing the free services used in Oslo, informants would describe how they viewed the service providers rather than the service itself. The service providers were described as really kind, nice or helping and this was seen in relation to the fact that the services they gave were free. In this instance it should be noted that for example in Poland, informal payments were used to soften health workers' attitudes towards patients (Lewis 2000). The relationship between the free service at the Pro Centre and the health personnel that worked there was articulated by an Eastern European woman like this:

[...] taking care of all people without charge, with that, you know, this caring, they have care for them, they care about their health, if not maybe there could have been many out there, maybe they are dead in the streets [...]

In this sense care is not only seen as the act of giving medical care, but it is also linked to more emotional intentions. By not demanding money it is like this care is seen as an act out of compassion guided by the desire to *really* help and be kind. It is then almost as the service providers do this without payment as an act of altruism. This idea of care is then contrasted to the services in a home country where the issue of money is brought up even before you enter the clinic (McIntyre et al. 2006, Ensor 2004, Alubo 2001). The health personnel in their home countries are seen as being controlled by their desire of money and their care can only be bought with money, which in many cases is the actual fact (McIntyre et al. 2006, Alubo 2001, Lewis 2000). Money is in this way conceived as a corrupting factor taking away the ideal and emotional aspect of care and treatment, thus reducing it to a commodity only some can afford to buy.

The findings of the positive view towards health services received at the Pro Centre are linked to the fact that it is free and available for all. This should be seen in the context of how health care services are provided and managed in Nigeria and Eastern Europe, where money is a determining factor throughout the whole health-seeking and treatment process. The argument of a correlation between free services and the motivation for seeking care, both for preventive and symptom-based reasons, is supported in this study. That the clinic was free was stated as one of the most important reasons for going to the clinic in the first place, and was additionally seen as important in relation to preventive health issues. Furthermore, having a service without charges also affected how the health personnel were perceived. When money was out of the picture the perceived role of care and treatment changed and became more ideal. This pure role of care and treatment seemed to create more trust toward the health personnel. Trust towards health personnel is extremely important for sex workers as they are often faced with stigmatization or bear with them self-stigma (Stadler & Delany 2006, Wong et al. 2006, Vanwesenbeeck 2001).

5.3.1 Health care rights and payment for health care services

Some informants brought up the issue of health care rights, when discussing whether they had been in contact with other health services than the Pro Centre in Norway. Some said that they knew going to hospitals or specialists would be very difficult and expensive due to their

lack of health care rights in Norway. One of the Eastern European women expressed the issue of health care rights like this:

I am not registered here; I am same as a tourist. Then I have to pay. But I don't like to register myself to, to somewhere that I am not anonymous. This is also a problem, it's difficult [...]

However according to Norwegian law citizens of EEA member countries that are in Norway as tourists are entitled to emergency and necessary treatment covered under the National Insurance Act. EEA citizens should bring with them the European Health Insurance Card, when traveling as a tourist to Norway, verifying this entitlement¹⁹. Still, this does not mean that this service is free, as all citizens in Norway have to pay up to a certain amount before they get free medical coverage by the National Insurance Act²⁰. This means that if a tourist, from a member country in EEA, goes to the emergency clinic²¹ one still have to pay a certain fee. Moreover some migrant sex workers come from countries that are not part of EEA, and they need private travel insurances to cover their medical expenses in Norway²². Such countries for example include Russia and Albania. In addition, being here as a tourist does not give the right to see a specialist if it is not acute. Many of the Nigerian women have staying papers in European countries like Italy or Spain, which are member countries of EEA, still many of the women in this study pointed out difficulties with obtaining hospital cards, or papers that would give health care rights in these countries. It is then probable that it is difficult for them to obtain the European Health Insurance Card, or they are not aware of what rights they do or do not have. Sex workers staying in the country illegally are only entitled to acute and emergency care, however it might be difficult for them to access hospitals or emergency clinics out of fear of being deported (Alexander 2004). The essential part then becomes where one draws the line between what is defined as emergency and acute treatment. In this study most of the migrant sex workers were here as tourists, and some

¹⁹ <http://www.nav.no/English/Staying+in+Norway/Tourists+in+Norway>

²⁰ <http://www.nav.no/page?id=354>

²¹ The term 'emergency clinic' is used to here to refer to the Norwegian health service 'Legevakten'

²² <http://www.nav.no/English/Staying+in+Norway/Tourists+in+Norway>

came from countries that are not part of EU or EEA. Furthermore, one of the women was here without any legal papers, hence she could be considered to be an illegal immigrant.

An issue that came up during the interviews was what happened in situations where people needed different procedures or treatment, but were not entitled to this. Both the sex workers themselves and service providers gave examples of health care services that were given free of cost, even when patients lacked the proper health care rights for these procedures. These services ranged from abortions arranged for and paid by the services themselves, to operations performed at hospitals in Norway. However, these situations only occurred on an ad-hoc basis, outside the regular health system, and service providers ascribed such incidents to solidarity of health personnel:

I think it is a combination of idealism and frustration. A frustration rooted in how the system is so bureaucratic and rigid, preventing the patients from getting the medical assistance they need. A sort of kindness and empathy, it does exist, but it gets harder and harder to make it happen, because everything is measured, weighed and counted in money. So it gets more and more difficult, but it still happens, it actually does.

There were also examples concerning the opposite, where women had not been able to go through with advised treatment due to the costs. These cases were difficult for service providers to deal with and they often expressed frustration towards what they perceived as rigidity within the health care system. At the same time they also pointed out that it was a difficult issue, as one service provider reflected:

We have a health care system that is overloaded with long waiting lists, so we cannot provide all people that come to this country with free medical assistance. However, in my opinion we have a certain responsibility for those that are here in Norway. They should at least get emergency care for free, but where does one draw the line for what emergency care consists of?

Health care rights can be a structural barrier preventing migrant sex workers from getting the treatment both they themselves and health personnel see as necessary. This is not confined to a Norwegian setting, but has been found in other places as well. Wong et al. (2006) points

out how Chinese migrant sex workers in Hong Kong are excluded from utilizing public health services, and that the private health services are not an affordable alternative for many. As a result many women in this study reported a delay in seeking help, self-medication or traveling back to China for treatment. When lacking the proper health care rights the women themselves have to pay for the medical expenses and this cost is frequently not affordable. This is a difficult situation for the women themselves and service providers. The free services at the Pro Centre's clinic might be enough for some women, as they used it mainly for gynecological exams, minor health complaints and blood tests. However in some cases there is a need for specialists and in these cases the question of cost, becomes an issue for those that have few health care rights. For example, Mak (2004) argues that cervical cancer screening should be a part of the basic health care for sex workers, as this type of cancer can be transmitted through some sexually transmitted strains of the Human Papilloma Virus. At the Pro Centre's clinic all women over 25 years are offered to take a pap smear²³ if they have not done it before. Likewise this is offered to those over 25 years that have not taken such a test for 3 years. However, if the test shows that the patient needs more examination or treatment, those that do not have health care rights have to pay for these themselves. Service providers gave examples of cases where this had occurred, and where patients did not go through with the recommended follow-up due to economic constraints. Hence, it is not a question of the individual's rational choice between weighing potential costs against potential benefits, because in these cases the costs are not economically bearable. In this case the individual's decision making is in itself not enough to obtain treatment.

5.4 Experiences from different health care services in Norway

There were five informants that had been in contact with health care services other than the Pro Centre. The places visited were the emergency clinic²⁴, the Olafia clinic, Ullevål hospital and two different private dentists. Still, most of these appointments had been facilitated through or with service providers from the Pro Centre or Nadheim.

²³ Papanicolaou test is a way of screening female patients to changes in the cell of the cervix as significant changes can be treated, thus preventing cervical cancer. <http://www.womenshealth.gov/faq/pap-test.cfm>

²⁴ Legevakten

There were two consultations at Ullevål hospital, one regarding an abortion and the other concerning an x-ray in combination with an examination by a specialist. In both these cases the informants had not paid for the services. Two of the informants had been to the dentist here in Oslo. The Pro Centre's yearly report has noted that there has been an increasing demand for dental services among sex workers (Pro Sentret 2009). Both women that had been to dental services in Oslo, said they had to pay for it. Still, one of them told she got some discount because the dentist knew her situation. The majority of these women were very content with their experiences, and they expressed satisfaction with both the medical treatment and the meeting with the different health personnel. Nevertheless, the emergency clinic was the one service where both sex workers and service providers expressed differing opinions.

5.4.1 The emergency clinic

The emergency clinic was the place most visited by the sex workers or someone they knew. There were mixed perceptions about this service and the women had different experiences. Nevertheless, one main comment made by all was that they had to wait a long time, before they were attended to. How this waiting time was considered and interpreted varied among the women. One of the Nigerian respondents told a story about a friend of hers that had been beaten by a customer and taken to the emergency clinic by the police. Once they arrived at the clinic they were told to wait, and according to the informant, left alone and unattended. This is how she described the situation:

[...] the health personnel told her; " yeah there are lot of people waiting for us, you just came, like you have to wait", like, while she's bleeding terribly, it can affect something else, just something to give her to stop the bleeding, no water to whom wash the face, they didn't. They told her to sit down, you are not going to die, it's normal, it's bleeding.

After waiting and talking with other friends that had had a similar experience at the clinic they decided to leave. The battered woman was then attended to by the respondent herself, as she described:

[...] emergency ward in clinic, there she was brought to, but we left. After one hour or two hours we left, we didn't see nurse, because they didn't answer, they told us we should [wait], there are people here for six hours, four hours, we have to wait, but we couldn't wait, because she was beaten, she need something, so we have to take her home and like take a shower, use the warm water, put, hot, something rub on her nose, give her some pain relief, that's what we, I did for her.

This experience was clearly upsetting, and this Nigerian woman especially underlined what she saw as a mismatch between the name of the service; emergency and the received service. She articulated it in this way:

[..] because we believe in other country [outside Nigeria] when they say emergency, you must take emergency as minute the person come, you must take the bed, or a chair, you must take the quick action to the case [...] because it's called emergency, yeah, it's between life and death, they have to answer the person directly, even if it's not so terrible, but you have to put a person [staff] there to take care of the person, but we were so disappointed that, I don't know if it's other places in Norway, but we were so disappointed. Emergency, they don't answer what they call themselves, it's better they are private or normal hospital, not emergency.

Clearly the Nigerian women's perception of this situation did not fit with the staff's evaluation. Through her account it is clear that they felt that their friend's situation was not taken seriously enough, and that they were even seen as being overdramatic. This was emphasized by the account of the health personnel's response about her not going to die and that they were left unattended while waiting. This did not correspond with the respondent's expectations embedded in the concept of an emergency clinic. What was seen as an initial negative response, turned out to be even more disappointing since this led to the decision to leave before getting medical care. Still, from this woman's story it is difficult to find indications of discrimination associated with sex work. Even the woman herself does not include such reflections; she rather expresses disappointment towards the waiting which in this case resulted in lack of emergent care.

Two Eastern European women that had been to the emergency clinic were more satisfied with their visit, however their reasons for going there were not violence related and the degree of acuteness in their conditions was expressed in a less severe way. One informant had been there with a strong headache and another with an ear infection. Even though the respondents described their conditions as so severe and painful that they felt that they had to see a doctor within a short time span, it was portrayed as relatively undramatic. Nevertheless, these women also pointed out the waiting time at the clinic. However, one of the women said that this was not surprising and it was also usual in her home country, she expressed it as normal and expected. This is how she explained it: *[...] they was very nice to me and they give me help, it was little bit long waiting time, but in my home country it's same you know, everywhere I think you have to wait.*

Another Eastern European woman said she had heard mixed stories about the emergency, but that she herself had had a good experience. She underlined that she did not think that the reason for some having negative experiences was related to sex work. Rather she explained it in terms of the people working there and their personalities or motivations for choosing this profession:

[...] you know I don't think it's not about work [sex work], because when girl go to Legevakt [the emergency clinic] they mostly not see that they are working in the street, it's just about people, everybody is different, somebody is nice, somebody is not good, you know. I think, those who want to work like doctor to help people they must to, to want to do this from inside, you know, some people go to study doctor and they don't like people and just see, see his needs to be rich, you must to love people, you must to want to help people, it is special, you must be special. So it's a gift. It's not because the work [sex work], in Legevakt [the emergency] they're just different people, some is nice, some is not.

The waiting time was also commented by the service providers. However, this was also viewed in terms of the capacity of the service and not as discrimination against this specific group of women. Even though the waiting time was seen as negative some pointed out that this was the same for everyone:

I have not experienced that the women [sex workers] say something negative about health personnel, but they often think that the waiting system at the emergency clinic is a bit slow. It really is incredibly slow and bureaucratic, and at the emergency they don't distinguish between those that have residency or not. You just sit there and wait and then the nurse comes and does an evaluation of how high up on the priority list this you should be. One time I was there with a woman [sex worker] and we were told to wait six hours, but instead we decided to go to another emergency clinic instead. I don't know, in one way I feel a bit sorry for them [personnel working at the clinic], because I am sure they have a lot to do, but I think this is a system that could be changed to the better.

Still, one of the service providers pointed out that she on a couple of occasions had experienced that the emergency clinic had sent home women, sex workers, without giving the necessary medical care. One of the cases was quite serious and this woman ended up being hospitalized for a long time, as the service provider explained:

[...] One girl came here with what turned out to be a serious kidney failure, where her face started to swell up more and more. She had been sent home from the emergency clinic being told to await the situation. I don't think they would have done this to a Norwegian patient. So I called them and yelled at them, making sure that she could come back and get a proper examination. The end of the story was that she became hospitalized for a long time, because she was seriously ill.

In this case the service provider states that she thought this woman was being treated differently, because she was not a Norwegian citizen. However there is no link towards sex work and it might therefore seem to be more a question about legal rights to treatment. It is difficult to say what reasons or evaluations that lead to the health personnel's decision, since their side of the story is not represented. At the same time, it is also important to remember that health personnel do mistakes among all patient groups.

The negative comments made about the emergency clinic were mostly related to the waiting system. This was seen as acceptable or even expected by some, while for others it was colliding with what they expected from such a service. Still, there were no findings

indicating sex work as a reason for discrimination or negative behaviour from health personnel towards these women.

5.4.2 Experiences from service providers

The service providers interact with a lot of sex workers over time and their experiences are an important source of information regarding how these women are met and treated at different health care services in Norway. This is supported by the fact that service providers often accompany their users or patients to different health and social services upon request. As a general comment the service providers were satisfied, but they had some negative episodes that they had experienced when following women to different health services. In one of the cases a service provider had accompanied one of her clients, a young woman, to a pre-examination before an abortion. This is the service provider's account of what happened in this situation:

[...]I was waiting outside in the hall, while the young girl was in with the doctor doing the examination. Then I hear the doctor's voice through the door, saying: "You work in the streets? You have to use a condom; you have to use a condom!" When the girl was finished with the examination I walked into the office and the girl is crying and crying. I then notice that the doctor has printed out a picture of her unborn twin fetuses, and placed them at the table in front of her. The girl was devastated and I was thinking; the doctor would never have done that to me or anyone else that did not work in the streets, or maybe the doctor had a really, really bad day[...]

For the patient in this story this was clearly an upsetting episode. The service provider told that the organization had filed a complaint in the aftermath of the episode, so as to make clear that such behaviour is not accepted. They had also spent a lot of time talking to the woman, explaining that this is not a right or legal conduct for health personnel. Nevertheless, the young woman still had to carry this meeting and experience with her. It is hard to say whether this episode would affect her future health behaviour in a negative manner; however it can have an indirect consequence if this woman shares her experience with other women in the sex work community. This can influence other girls' perceptions about health care services and reconfirm negative expectations and stigma. In this particular situation we do

not know how the doctor treated other patients. Thus it is difficult to say if this particular doctor discriminated the woman because of what was perceived as inconsistent condom usage with customers, or if it was just a strong expression of a negative attitude towards abortion in itself. Still, the remarks made about working in the streets and condom usage, are directly linked to sex work implying that this woman was displaying risky sexual behaviour.

Other examples where service providers have experienced negative attitudes towards the women have not necessarily been related to their roles as sex workers, but have more xenophobic characters. It is then a display of negative attitudes towards them as foreigners and it is based on a perception of unfairness since they think these women or patients get “special treatment”, while Norwegians have to work hard for the same treatment.

One time when I accompanied a woman to the hospital for an examination there was an unpleasant incident. Most of the communication was in Norwegian, but the foreign woman understood that it was about her and the doctor was saying things like; “why on earth do all these people come here? They should just go home. I pay my taxes and have always done so, but I never get anything for free, while these people just come here and get everything”. But it varies, I feel that the ones I have followed to different health services have been received well and taken good care of. However there are some episodes from time to time than can be quite shocking, but I think that is just what they are; episodes, and that they do not represent the general picture.

There were some findings of discrimination of sex workers in health care services outside the services targeted at this group. These were not told by the women themselves, but were based on service providers’ experiences over time with many different women. Still, the service providers’ general impression was that these incidents were rare and that both they and the sex workers were generally satisfied with the health care services they had been in contact with. Other studies have found that sex workers have been discriminated against by health personnel, the consequence being that this group finds it difficult to seek help (Chacham et al. 2007, Stadler & Delany 2006, Wojcicki & Malala 2001, Aral et al. 2003, Montgomery 1999).

5.5 Overall discussion of the chapter

This chapter has looked at female migrant sex workers' health behaviour in terms of the usage or non-usage of different health care services. It was found that expectations of stigma and discrimination, as well as a strategy of separating sex work from one's private life, prevented these sex workers from disclosing their experiences with sex work to health personnel. It was found that most women used two doctors: one for their "normal life" and one for "their lives as sex workers". Moreover, it was discussed how services targeting sex workers motivated usage, as this setting circumvented the problem of disclosure. In addition, these services were viewed as encouraging, as sex workers felt they gave protection both in a practical aspect, with materials like condoms, but also at an emotional level by looking out for the women. The combination of different services motivated the women to use them, as they could get both health needs and basic needs covered at one place. The importance of the services was underlined by how some of the sex workers saw it as a home, and this was mentioned as a reason for their continued use of the services.

In this project, having a free health service was viewed as important, and it was found to act as a facilitator and motivator for seeking preventive and symptom-based care. Sex workers often contrasted the free service they received in Norway with health care services in Nigeria and Eastern Europe, where money often is a determining factor throughout the whole health-seeking and treatment process. The negative view of services in their home countries was found to reinforce the positive view of services and service providers in Norway. The issue of paying for services in the absence of health care rights was seen as a probable barrier for many of these women's health behaviour in terms of service utilization.

As discussed in this chapter, there is little evidence that the women themselves or service providers have experienced negative attitudes or poorer treatment due to involvement in sex work. Service providers mentioned some examples of such a character; however they underlined that this was not representative for the general picture and that these were isolated incidents. Still, one might argue that one such episode is one too many. Additionally, it must be acknowledged that the experience for those sex workers discriminated against, due to sex work involvement, is probably reinforcing the self-stigma and perceived social stigmatization of this group. This is even more so when such stories are shared among members of the same community. This can affect their health care utilization, as negative

attitudes and expectations towards health personnel are likely to act as a discouragement for seeking care.

6. Conclusion and future recommendations

In this thesis it has been argued that social and cultural contexts shape, influence and form beliefs about health and illness. How individuals understand health and illness depends on their cultural knowledge, previous experiences and how symptoms are reacted to and interpreted by other people in our social networks. Hence, the cultural and social environment is the basis for how individuals learn “appropriate” ways of being healthy or ill. The same is also true for how different illnesses are explained. Thus, explanatory models are not fixed and can change as new experiences are made or new knowledge or advice occurs. The examples of “toilet disease” and pain were used to show how Nigerian sex workers’ perceptions and explanation of illness did not coincide with those of the service providers. This was framed in a discussion on how the biomedical perspective is pervasive in a Norwegian health care setting, giving rise to challenges and/or conflicts when confronted with other beliefs on health and illness. This was also seen as an explanation for why the Eastern European women were seen to have more defined needs, frequently stating their health complaints by using biomedical expressions and labels, such as “sinus infection” or “urinary tract infection”.

Within this line of reasoning, it was discussed how mental health is often interpreted and understood differently across cultures and social settings. This was especially clear in how service providers saw some health complaints, such as “body pain”, to be an expression of psychological distress. However, this was viewed as difficult to approach, as the sex workers had different perceptions of these conditions and how they should be treated. Concerning, the question of mental health needs it was found that several migrant sex workers had problems related to sleeping. This was caused by worries and thoughts. Still, the women did not see this as an issue belonging in a health care setting. Gaining knowledge of individuals’ health beliefs can shed light on how one can address and understand such health complaints in an appropriate way. One way of doing this is through an increased focus on cross-cultural communication in health care settings. Here, cultural mediators were found to have a central role to play. The Pro Centre is using cultural mediators as a part of their work, still findings

suggest that these should be more involved in health matters and have more defined guidelines and training.

This study confirms the notion that sex workers are committed to condom usage with clients. However, it was suggested that the picture was different with regular partners. The perception of non-usage of condoms with regular partners was based upon service providers' perceptions. They pointed out power-relationships between the women and their partners as a reason for non-usage of condoms, whereas literature has also shown how non-usage of condoms can be a reflection of these women's need for intimacy and closeness. Moreover, as it was discussed in chapter four, there are challenges related to promoting hormonal contraception cross-culturally, as certain health beliefs can result in low usage. Additionally, unwanted pregnancies were perceived to be a result of non-usage of contraception with regular partners, and not due to unprotected sex with clients or condoms breakages. The question of contraception and fertility needs to be further investigated as this will have implications for how health workers should address these issues in their further work. In a Norwegian context, it is important to gain more thorough knowledge about the social and emotional realities, as well as challenges, that these sex workers face when combining commercial sex with emotional relationships.

As argued in this thesis, individuals are not isolated actors, but parts of wider social and cultural networks. Social relations affect our behaviour, through norms, power relationships, motivations and discouragement. Regarding health, we often listen to advice from our friends or families on what action to take or not take. In this way social relations affect our treatment seeking process, as we often consult others for recommendations on treatment possibilities. The empirical findings, discussed in chapter five, highlights how fear of moral repercussions made it unthinkable for most sex workers to tell health personnel about their sex work experience. In addition, a need to separate one's life into two realms was seen to lead to a strategy of using two doctors. Services targeting sex workers were seen have a positive effect on these women's health behaviour as this meant avoiding the problem of disclosure. Moreover, having a free health care was seen as a motivating factor, and was stated as one of the most important reasons for using this service. However, the question of paying for services in the absence of health care rights was seen as a probable barrier for

many of these women's health behaviour in relation to treatment opportunities. Still, it was pointed out that sometimes health personnel would put the law aside, performing services for free outside the formal system. This project found little evidence supporting the assumption of discrimination in health care settings due to involvement in sex work. The general picture being that these women were satisfied with how they were met and treated by health workers outside the Pro Centre's clinic.

All in all, this thesis has shown how health beliefs of migrant sex workers influence their health behaviour in terms of how different illnesses are interpreted, explained and what actions are considered most suitable. It has been argued that health beliefs are culturally and socially constructed, meaning that changes occur across time and space. Additionally, individual behaviour is linked to wider social and cultural relations also guiding our behaviour through norms, advice, emotions and power relationships. The findings from this study should be seen as specific for this study's cultural and social context. However, some of the questions raised and discussed here are valid for other groups as well, especially the issue of how health and illness are interpreted differently across social and cultural contexts. The results from this study can be a contribution to the field of how health care can be delivered to various cross-cultural groups in Norway, such as refugees and immigrants. Furthermore, health care rights can be a structural barrier for preventing migrant sex workers from getting necessary treatment. This is related to a wider debate on illegal immigrants. Hence, the challenges explored in this project can be seen as supplements to this discussion.

This study is a contribution to a relatively silent research field in Norway. It has shed light on how female migrant sex workers understand their own health, how this influences their health behaviour and what choices they make regarding treatment opportunities or prevention efforts. Even though this project has not been able to explore the health behaviour of those sex workers that are out of reach for service providers, the lack of research on the issue of health and migrant sex workers in a Norwegian context makes this study and findings a valuable starting point.

6.1 Future recommendations

As for future research the question of mental health should be addressed. Here, much more knowledge is needed to understand the extent of this need and how this is defined by the sex workers themselves. On a general level, more studies are needed that focus on the social worlds of sex workers. In particular, the relationship between condom usage, hormonal contraception and unwanted pregnancies in relation to intimate partners needs to be examined.

Almost five months have gone by since it became illegal to buy sex in Norway. The Fafo report (Tveit & Skilbrei 2008a) that was made as a preparation for the law was also intended to provide material for future evaluation. However, since no assessment of health was included, it will be very difficult to determine how this law has affected the health behaviour of female migrant sex workers in Norway. Still, it is highly recommended that future research addresses this question, as one of the arguments for passing the law in the first place was protection of these women. Based on the empirical findings, discussed throughout this thesis, I strongly recommend that the services targeting sex workers, in particular the health clinic at the Pro Centre, continue their work with this group of sex workers. These services are fundamental for the women's health behaviour in terms of cost, acceptance, understanding, prevention efforts and treatment seeking. In addition, the service providers at these organizations are increasingly learning how to understand and interpret these women's health beliefs to better attend to their needs. In a relatively neglected research area, service providers and the women themselves are the ones holding the key to how female migrant sex workers' health behaviour in Oslo, Norway should be addressed in future policy implementation.

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Appendix A Information letter for sex workers

Request for participation in the research project “Health behaviour among female migrant sex workers in Oslo, Norway”

Background and purpose

This is a request for you to participate in a research study where the aim is to better understand how female migrant sex workers seek and receive health care services in Oslo, Norway. In this study, I will interview sex workers and those providing services to women who sell sex. The contributions from this study will hopefully give valuable recommendations to future interventions that can benefit sex workers. This project is done as a part of the master programme “International Community Health” at the Faculty of Medicine, University of Oslo. This project has been notified to Privacy Ombudsman for Research (NSD) and has been approved by the Regional Committee for Medical Research Ethics Sør-Øst, Norge (REK Sør-Øst).

My aim is to increase knowledge about the health of female sex workers that are in Norway temporarily. In order to do this, I wish to interview you, since you have firsthand knowledge of your own situation. I would like to discuss issues related to your health and health behaviour. Important questions will be: where you go to seek health care, experiences you have had with Norwegian health care facilities and personnel, and what you think about your own health and health needs.

Information about your participation in the project

The questions will be asked in an interview session between you and me, and they will last for approximately 1 hour. I will take notes while we talk, and if it is okay with you, I will use a tape recorder. You may end the interview at any time you wish and you do not have to discuss things you do not want to. It could be that you will be asked to meet with me again for a longer interview discussing things from our first meeting in more detail. The participation in a follow-up interview is entirely up to you. There will not be any consequences for you, if you do not wish to participate in this study, or if you withdraw from the study during the process. The participation in this project is voluntary and you will not be paid to do so. The time of meeting will be decided by you, so that it does not collide with your working hours or other activities. If you wish to change something you have said or wish to withdraw the information shared in the interview, you are free to do so anytime before the date of publication which is 18.05.2009.

What happens with the information you share?

Your identity will be treated with confidentiality, and my supervisor and I are both bound by the promise of professional secrecy. I will not write down your name or other identifiable information like age or country of origin. The interview will be written down and in this transcription you will be given a new name. Names of other persons, places and/or other identifiable information, which comes up during the interview, will be changed so that you as a contributor cannot be recognized in the final paper. The information that comes out from the interviews will only be handled by me. The information given will be used only for this study.

Findings from the study will be published through the University of Oslo, and your identity as a contributor will be made anonymous within 01.08. 2009. The final anonymization of the

information means that indefinable information from the interview will be deleted and changed in the transcriptions, and that all recording will be deleted.

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Appendix B Interview guide, sex workers

Theme: Health needs

Example of question: Last time you went to see a doctor or a nurse, what was your reason for going there?

Example of question: Have you been to see a nurse or a doctor in Oslo?

Follow-up, if yes: Where did you go?

Follow-up, if yes: Can you please tell me about the first time you saw a doctor or a nurse in Oslo?

Example of question: Can you tell me about a situation where you felt sick or had any symptoms?

Follow-up: What did you feel?

Follow-up: What did you do?

Example of question: What do you think is the most common reason to go to see a doctor or a nurse for women who sell sex?

Theme: Self-perception of one's health in relation to sex work

Example of question: How would you describe your health?

Follow-up: Has it changed since you started selling sex?

Example of question: Do you think selling sex affects your health?

Example of question: Do you sometimes discuss health issues with your friends or other women you work with?

Theme: Self-perception about well-being/mental health

Example of question: How do you feel about yourself, how do you feel inside?

Follow-up: Has this changed since you started selling sex?

Example of question: Do you have any problems with sleeping, headaches or muscle pain?

Follow-up, if yes: Why do you think you have these problems?

Follow-up, if yes: Did you have them before you started selling sex?

Follow-up, if yes: Have you told a doctor or nurse about this?

Follow-up, if yes: What did they say?

Probe: Did you agree?

Follow-up, if no: Why did you not tell them about this?

Example of question: How do you think other people look at women who sell sex?

Theme: Health access

Example of question: Do you have a regular doctor in your home country or staying country?

Follow-up, if yes: Does this doctor know that you sell sex?

Follow-up, if no: Why not?

Follow-up, if yes: How did the doctor react when you told him/her?

Example of question: Have you ever needed longer treatment or surgery while in Norway?

Follow-up, if yes: Where did you go?

Follow-up, if yes: Who paid for it?

Example of question: Do you know of different places to see a nurse or a doctor in Oslo?

Theme: Contact with services targeting sex workers

Example of question: Have you ever been in contact with Nadheim or the Pro Centre?

Follow-up, if yes: How did you hear about this/these places?

Follow-up, if yes: Why did you decide to go there?

Example of question: Have you ever been to the Pro Centre's health clinic?

Follow-up, if yes: How did you hear about this/these places?

Follow-up, if yes: Why did you decide to go there?

Follow-up, if yes: How was going there for you?

Example of question: Are there many other women that go to these places?

Probe: Do you know their reason for going there/not going there?

Probe: Do you know where the women that do not use the health clinic at the Pro Centre go?

Probe: What do you think these women do if they have a health problem?

Example of question: Have you met any people from Nadheim or the Pro Centre in the streets, giving out condoms, facilitator, paper or information about services and where you can see a doctor or a nurse?

Follow-up, if yes: What did you think about this?

Probe: How did it make you feel?

Theme: Cost of health care

Example of question: Would you still come to the Pro Centre's clinic if you had to pay?

Example of question: What do you think about a free health clinic for women that sell sex?

Theme: Health communication

Example of question: How would you describe the communication with Norwegian nurses or doctors?

Follow-up: Do you sometimes have problems with understanding them, or expressing yourself?

Probe: Has this changed if you have seen the nurse or the doctor several times?

Example of question: What do the health workers ask you about?

Example of question: What do you ask them about?

Theme: Health experiences

Have you ever been to the emergency clinic or the big hospital or other health services in Oslo?

Follow-up, if yes: Can you please tell me about that?

Follow-up, if yes: Did you have to pay for it?

Follow-up, if no: Do you have a friend that has been to any such place?

Follow-up, if yes: Can you please tell me about that? (Reason for going, payment)

Follow-up: How did the doctors/nurses treat you/your friend?

Example of question: Is going to the doctor or nurse different here than from your home country or staying country?

Follow-up, if yes: How is it different?

Theme: Reproductive health

Example of question: Do you use condoms?

Follow-up, if yes: Can you show me/tell me how and when you use it?

Example of question: Has a client asked you to have sex without a condom?

Follow-up, if yes: What do you reply?

Follow-up: What do you think other girls do/say?

Example of question: Have you ever had a condom breakage?

Follow-up, if yes: What did you do?

Example of question: Do you use other contraception, like pills or patches?

Follow-up, if yes: Why?

Follow-up, if yes, but stopped: Why did you stop using?

Probe: Did you discuss this with a nurse or a doctor?

Follow-up, if no: Why not?

Follow-up: Will you use this type of contraception in the future?

Probe: Why/Why not?

Example of question: Have you ever been pregnant while selling sex?

Follow-up: What did you do?

Probe: Who was the father?

Example of question: Have you ever had an abortion?

Follow-up, if yes: When?

Follow-up, if related to sex work: Who paid for it?

Appendix C Information letter for service providers

Forespørsel om deltagelse i forskningsprosjektet "Health behaviour among female migrant sex workers in Oslo, Norway".

Bakgrunn og hensikt

Dette er et spørsmål til deg om å delta i et forskningstudie hvor formålet er å bedre forstå hvordan kvinnelige sex arbeidere uten bosetningstillatelse søker og mottar helsehjelp i Oslo, Norge. Dette er et kvalitativt prosjekt, og både sex arbeidere og de som yter assistanse til disse kvinnene gjennom organisasjoner eller prosjekter vil bli intervjuet. Bidragene fra dette studiet vil forhåpentligvis kunne gi viktige anbefalinger for fremtidige tiltak som kan være gunstige for denne gruppen og de som jobber med den. Dette prosjektet gjøres som en del av mastergraden "International Community Health" på det medisinske fakultet ved universitetet i Oslo. Prosjektet har blitt meldt til Norsk samfunnsvitenskaplig datatjeneste (NSD) og er godkjent av Regional komité for medisinsk forskningsetikk Sør-Øst Norge (REK Sør-Øst).

For å øke kunnskapen om denne gruppen helse, ønsker jeg å snakke med personer som jobber med å assistere kvinner som selger sex. Det jeg ønsker å snakke med deg om er spørsmål relatert til denne gruppens helse. Viktige temaer vil være: hva slags helseproblemer de har, hvor og hvordan de søker helsehjelp, samt holdninger og erfaringer de har til det norske helsevesenet. I tillegg ønsker jeg å sette fokus på dine refleksjoner rundt disse temaene og hvordan ditt arbeid påvirker disse kvinnens helse.

Informasjon om undersøkelsen

Spørsmålene vil foregå som et intervju mellom deg og meg, og vil vare cirka en time. Jeg vil ta notater mens vi snakker sammen og båndopptager, hvis det er greit for deg. Du er fri til å avslutte intervjuene når du selv vil og du trenger ikke snakke om ting du ikke ønsker. Det kan være at du blir spurt om å delta i en gruppediskusjon og/eller et oppfølgingsintervju, deltagelse i dette er helt frivillig og opp til deg. Det vil ikke ha noen konsekvenser om du ikke ønsker å delta i dette prosjektet eller om du ønsker å slutte i løpet av prosessen. Deltagelse i dette prosjektet er basert på frivillighet og du vil ikke få betalt. Du bestemmer imidlertid tidspunktet for når vi skal møtes slik at det ikke kolliderer med din arbeidstid eller andre oppgaver. Dersom du ønsker å endre på noe du har sagt eller ikke ønsker at intervjuet skal brukes likevel, har du anledning til å trekke tilbake samtykket ditt frem til publiseringsdato som er 18.05. 2009.

Hva skjer med informasjonen om deg?

Din identitet og det vi snakker om vil bli behandlet med konfidensialitet. Jeg og min veileder har begge taushetsplikt. Jeg vil ikke skrive ned navnet ditt eller andre identifiserbare personopplysninger, slik som alder eller opprinnelse. Intervjuene blir skrevet ned, og i denne transkripsjonen blir du gitt et nytt navn. Navn på personer, steder og annen mulig identifiserbar informasjon, som kommer opp under intervjuet, vil ikke bli brukt i oppgaven og blir endret slik at det ikke kan kjennes igjen i den endelige oppgaven. Informasjonen fra intervjuet vil kun bli behandlet av meg. Informasjonen som utveksles mellom deg og meg vil kun brukes for dette studiet.

Funn fra prosjektet vil bli publisert via universitetet i Oslo, og din identitet som bidragsyter vil bli anonymisert senest 01.08.2009. Den endelige anonymiseringen innebærer at all identifiserbar informasjon fra intervjuene vil bli slettet og endret i transkripsjonene og at alle lydopptak blir slettet.

Kontaktinformasjon

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Appendix D Interview guide, service providers

Tema: helsebehov blant sex arbeidere

Eksempel på spørsmål: Hva er dine tanker om helsetilstanden til kvinnelige sex arbeidere uten bosetningstillatelse?

Oppfølging: Er det forskjell mellom de ulike gruppene av sex arbeidere med hensyn til helsebehov og helsetilstand?

Utdypning: Hvilken gruppe er mest opptatt av helserelaterte spørsmål?

Eksempel på spørsmål: Har du diskutert helsebehov med denne type sex arbeidere?

Oppfølging: Er det noe de diskuterer, fremhever mer?

Utdypning: Kan du gi noen eksempler?

Tema: reproduktiv helse

Eksempel på spørsmål: Hva er ditt inntrykk av sammenhengen mellom kondombruk og kunder?

Oppfølging: Er det mange som har kondomsprekk?

Utdypning: Hvis ja, hva tenker du om det?

Eksempel på spørsmål: Hvordan er det med bruk av tilleggsprevensjon?

Oppfølging: Er det forskjell mellom de ulike gruppene av kvinner på dette?

Utdypning: Kan du gi noen eksempler?

Eksempel på spørsmål: Kan du si noe om denne gruppen i forhold til uønsket svangerskap?

Oppfølging: Er det noe forskjell mellom de ulike gruppene?

Oppfølging: Hvordan er det med betaling for abort?

Tema: helsetilgang

Eksempel på spørsmål: Hva er ditt inntrykk av helsetilgangen for disse kvinnene?

Oppfølging: Hva tror du er avgjørende for om de søker helsehjelp i Oslo?

Oppfølging: Hva tror du er avgjørende for om de får helsehjelp i Oslo?

Utdypning: Kan du tenke deg noen tiltak som kan gjøre det lettere for denne gruppen å få tilgang til helsehjelp?

Eksempel på spørsmål: Er det mange av disse kvinnene som spør deg om hvor de kan få helsehjelp?

Oppfølging: Hvor henviser du dem i så fall?

Oppfølging: Kan du fortelle et eksempel?

Eksempel på spørsmål: Hvordan løser disse kvinnene kroniske helseproblemer, eller inngrep, som krever mer omfattende helsehjelp?

Oppfølging: Kan du si noe mer om det?

Tema: erfaringer med helsevesenet

Eksempel på spørsmål: Har du opplevd/fått høre hvordan disse kvinnene blir møtt av helsearbeidere i Oslo?

Oppfølging: Har du et eksempel eller en historie i forhold til dette?

Tema: hjelpeapparatets rolle i forhold til helse

Eksempel på spørsmål: Tror du det arbeidet du gjør kan påvirke helsen til denne gruppen sex arbeidere?

Oppfølging, hvis ja: Hvordan da?

Oppfølging: Har du fått noen tilbakemelding fra disse kvinnene?

Utdypning: Hva tenkte du om det?

Eksempel på spørsmål: Tror du at et lavterskel tilbud påvirker disse kvinnenenes helse?

Oppfølging, hvis ja: Hvordan da?

Eksempel på spørsmål: Hva tenker du om oppsøkende arbeid og disse kvinnenenes helse?

Eksempel på spørsmål: Har du noen gang gitt denne gruppen sex arbeidere informasjon om helse, eventuelt ytt helsehjelp?

Oppfølging hvis ja: Hva slags informasjon eller hjelp ga du?

Oppfølging: Hvem tok kontakt med hvem, hvor og hvordan?